Maryland
GOVERNOR'S OFFICE OF CRIME PREVENTION AND POLICY

STATE SUMMIT ON BEHAVIORAL HEALTH AND THE JUSTICE SYSTEM

Utilizing the Sequential Intercept Model (SIM) Mapping Initiative

October 2024

Prepared by:
Centers of Excellence

Governor's Office of Crime Prevention and Policy

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ACKNOWLEDGEMENTS

The Centers of Excellence would like to acknowledge all attendees for sharing their time and expertise at this two-day event. The Centers would also like to express deep appreciation to Dorothy Lennig, Bethany Young, Tanya Schwartz, John Moses, Lt. Steven Thomas, Jennifer Corbin, Judge Shaem Spencer, Angela Shroyer, TJ Humphries, Kristie Ardire, Annabelle Belcher, and Anne Pack for presenting at this event. Finally, the Centers would like to share deepest gratitude to Tammy Loewe, Keesha Wallace, Valerie Williams, Kristy Blalock, and Robin Jones for their assistance in facilitating the intercept focus groups.

This report has been prepared by Rachel Ames and Tatiana Reyes on behalf of the Centers of Excellence.

Recommended Citation:

Centers of Excellence. (2024). *State Summit on Behavioral Health and the Justice System: Utilizing the Sequential Intercept Model (SIM) Initiative*. Crownsville, MD: Governor's Office of Crime Prevention and Policy.

EXECUTIVE SUMMARY

Local and statewide sequential intercept model (SIM) workshops offer an opportunity to develop strategic plans, provide technical support, advance crisis intervention programming, and coordinate data and evaluation efforts. In October 2024, the Centers hosted the third in-person annual two-day SIM Summit. Based on a voting process, focus groups identified priorities within and across intercepts; the top three priorities for each group and across groups are listed below.

Intercept 0/1	Intercept 2/3	Intercept 4/5	Across Intercepts
Ensure equitable funding of crisis services, including mobile crisis and stabilization services. (19)	Strengthen legislative support for implementing programs and mandates, especially those without allocated funding. (18)	Expand access to community-based case management. (12)	Strengthen and expand the behavioral health workforce. (22)
Enhance first responder wellness. (14)	Develop universal prescreening tools during initial detention and hearings to enhance diversion opportunities. (11)	Ensure parity in the competitive grant process through training, promotion of collaborative applications, and expanded funding opportunities. (9)	Enhance collaboration across health care, public safety, and community services. (18)
Explore emergency petition reform. (12)	Enhance reentry support before release from incarceration. (9)	Curate a resource library to enhance information sharing and improve access for justice-involved persons and their support networks. (8)	Improve data sharing and resource access for continuity of care. (16)
	Formalize pretrial services and/or units that are individualized per jurisdictional needs. (9)	Enhance peer workforce development and funding for peer professionals. (8)	

To address these priorities, the Centers of Excellence recommends the Stepping Up initiative (*outlined in the "Recommendations" section*), a complementary framework to the sequential intercept model. Stepping Up supports local efforts to establish and achieve measurable goals, providing guidance for recommendations at the intersections of behavioral health, criminal justice, and public policy.

BACKGROUND

Section 13-4204 of the Health General Article established the Maryland Behavioral Health and Public Safety Center of Excellence in the Governor's Office of Crime Prevention and Policy (Office) to serve as a statewide repository for behavioral health treatment and diversion resources with the intent to increase treatment, prevent harm, and reduce detention of people with behavioral health conditions. Section 3-522 of the Public Safety Article established the Crisis Intervention Team Center of Excellence in the Office to provide technical assistance related to behavioral health crisis intervention to local agencies and to develop and implement a crisis intervention model program. Collectively known as the Centers of Excellence (Centers), this unit advises the Office on efforts that support Maryland communities in improving the criminal legal response to individuals with behavioral health needs, intellectual and developmental disabilities, and neurocognitive conditions by redirecting these individuals when appropriate to the health care system, thereby reducing unnecessary incarceration while improving public health and safety. As the statewide clearinghouse for behavioral health-related treatment and diversion programs, the Centers develop strategic plans to increase treatment and reduce detention for those with behavioral health needs in the judicial system, provide technical support for localities, advance crisis intervention programming, and coordinate with State agencies to measure program effectiveness.

To fulfill its charge, the Centers:

- Lead and develop a multi-year strategic plan with the University of Maryland to implement the recommendations determined by the *2020 Maryland Lieutenant Governor's Commission to Study Mental Health and Behavioral Health: State Summit on Behavioral Health and the Justice System*.[1]
- Provide technical assistance to local governments for developing effective behavioral health systems of care that prevent and minimize involvement with the criminal legal system for individuals with behavioral health disorders.
- Facilitate local or regional planning workshops using the Sequential Intercept Model.[2]
- Coordinate with the Maryland Department of Health and the Behavioral Health Administration to implement and track the progress of creating an effective behavioral

[1] Substance Abuse and Mental Health Services (SAMHSA) GAINS Center. (2020). *Maryland Lieutenant Governor's Commission to Study Mental and Behavioral Health: State Summit on Behavioral Health and the Justice System*. https://mgaleg.maryland.gov/cmte_testimony/2021/fin/1w2lWIzHMEGqu7XjMmRCtNvOjfxJyj6Ft.pdf

[2] The sequential intercept model was developed in the early 2000s by Mark. R. Munetz, M.D., and Patricia A. Griffin, Ph.D., to help states and communities assess available resources, determine gaps in services, and plan for community change. Please see the following resource for more information: Munetz, M., & Griffin, P. (2006). A systemic approach to the decriminalization of people with serious mental illness: The sequential intercept model. *Psychiatric Services, 57*, 544-549.

health system of care in the State relating to individuals involved in the criminal legal system.

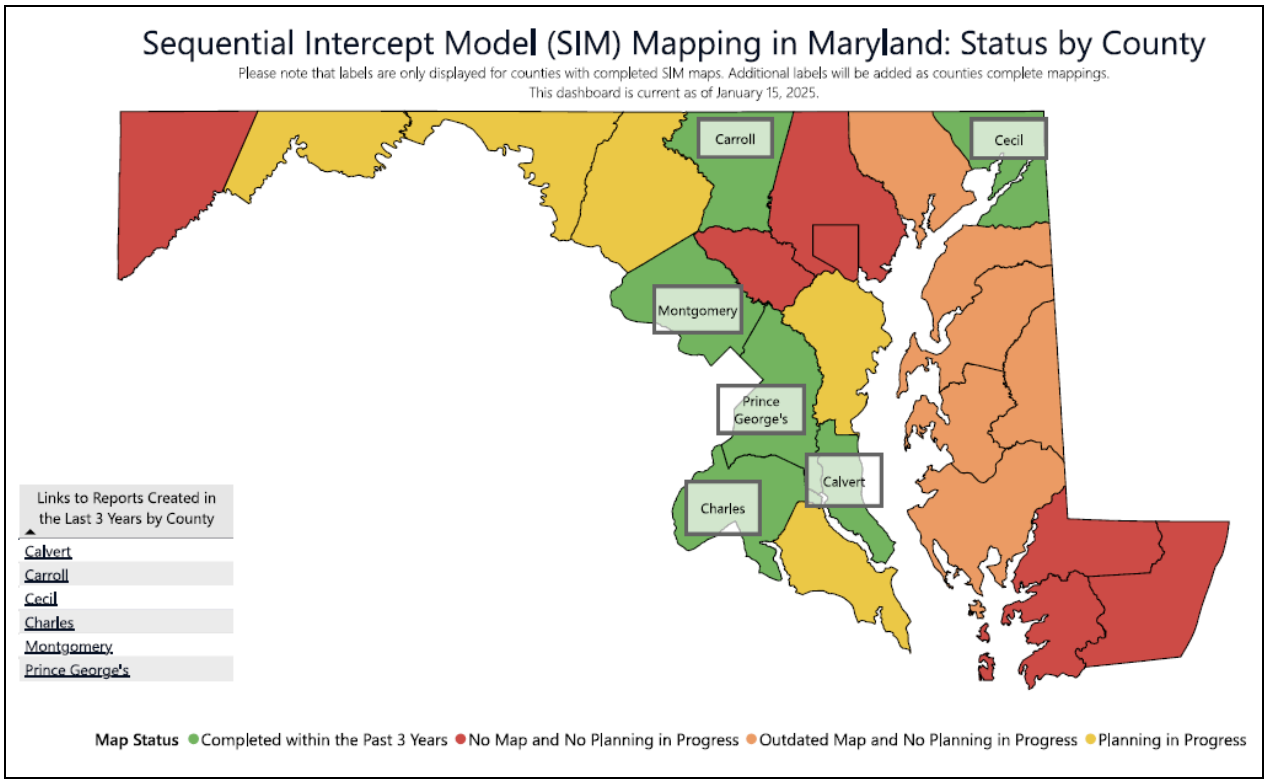
- Identify and inform any relevant stakeholders of any federal funding available to carry out the Centers' mission.
- Develop and expand cross-agency partnerships.
- Seek to establish and strengthen partnerships to identify and obtain diversion-related outcome data to support better deployment of behavioral health care resources and advance public safety.
- Guide the development of a statewide model for community crisis intervention services.
- Provide best practices, including logic models, strategic plans, data statistics, crisis intervention team models, toolkits, training/conferences, and relevant academic entities.

INTRODUCTION

The Centers use the sequential intercept model (SIM) as a framework for organizing and achieving their objectives, strategies, and tactics. The SIM helps communities understand how people with behavioral health needs come in contact with and flow through the criminal legal system. Through SIM mapping workshops, facilitators and participants identify opportunities to connect people with behavioral health services and prevent further system involvement. Workshops also guide people in connecting with services as they exit the criminal legal system. At SIM workshops, communities identify resources (e.g., substance use disorder treatment or transportation) accessible to people with behavioral health needs at different points on their path through–or away from, in the best-case scenario–the criminal legal system. Participants discuss and catalog programs and services available at several intercepts: in the community, after an arrest, in confinement, and as they prepare to return from periods of incarceration.

The workshops, conducted at the State and local levels, and their corresponding reports offer an opportunity to develop strategic plans, provide technical support, advance crisis intervention programming, and coordinate data and evaluation efforts. In 2024, the Centers conducted three jurisdiction-specific SIM mapping workshops and scheduled five additional workshops to occur in 2025.[3] The Centers aim to complete a SIM mapping workshop for all jurisdictions in the next two years. To illustrate these efforts, the Office created a data dashboard highlighting the completion and implementation of such reports and programs (*as illustrated on the next page*). To view the data dashboard, please visit https://gocpp.maryland.gov/data-dashboards/centers-of-excellence/.

[3] It is important to note that the Substance Abuse and Mental Health Services Administration (SAMHSA) completed additional SIM mapping workshops throughout the State.



In November 2022, the Centers hosted the first in-person *State Summit on Behavioral Health and the Justice System* which presented recommendations to improve access to housing, peer support specialists,[4] and crisis intervention training. The Summit included discussions that led to recommendations to cultivate the behavioral health workforce, expand mental health courts, and create a shared data system. It also identified objectives, priorities, and actions to address each recommendation, as outlined in the 2023 strategic plan.[5] Using the 2023 strategic plan as a roadmap, the Centers continue to work with partner agencies to take the necessary action steps for each priority to fulfill its mission.

In September 2023, the Centers developed a procedure for jurisdictions to request a SIM mapping or remapping through an electronic form[6] accessible on the Office's website. This procedure formalizes the waiting list and ensures the continuity of the initiative to provide each

[4] Peer support specialists are not defined by regulation. Peer support services, however, are defined by Maryland Regulation § 10.63.01.02 as non-clinical activities provided by individuals in recovery from mental health or substance-related and addictive disorders, using their lived experiences and training to support others with similar challenges.

[5] University of Maryland, Maryland Crime Research and Innovation Center. (2023). *Maryland's Behavioral Health and Public Safety Center of Excellence Strategic Plan*. https://gocpp.maryland.gov/wp-content/uploads/Maryland%E2%80%99s-Behavioral-Health-and-Public-Safety-Center-of-Excellence-Strategic-Plan-7-24-23.pdf

[6] Governor's Office of Crime Prevention and Policy. *SIM Mapping Request*. https://docs.google.com/forms/d/e/1FAIpQLSdsgnaw5RnGdi7GDPnDRgDWI9o1ERBvafdu6LTkHC0l38evEA/viewform

jurisdiction with a mapping or remapping every two to three years (upon request). To enhance technical assistance efforts, the Centers also developed a general information request form.[7] This form ensures that stakeholders' inquiries are documented and can be processed efficiently, often with standardized fields to streamline the response and clarify the type of information being sought.

In October 2023, the Centers hosted the second in-person annual two-day SIM Summit which presented recommendations to continue to improve access to housing, cultivate the behavioral health workforce, and create a shared data system. Throughout the Summit, discussions repeatedly underscored the importance of fostering interagency collaboration and breaking down isolated efforts, ultimately leading to the recommendation to facilitate cross-agency collaboration. The Centers continue to leverage insights gathered at the Summit to further advance its mission.

In May 2024, the Centers worked with Policy Research Associates to host a third SIM facilitator training, resulting in the training of 56 individuals from various parts of the State. The Centers invited two trained facilitators to attend each jurisdictional mapping and requested six trained facilitators to support the annual State SIM Summit. The Centers intend to host mid-year refresher training(s) to reinforce key skills, update facilitators on new methodologies or changes, and ensure they remain confident and well-prepared to assist with SIM mappings and summits.

In October 2024, the Centers hosted the third in-person annual two-day SIM Summit, focusing on collaboration with partner agencies to identify service gaps and share evidence-based and emerging best practices that have been successfully implemented across intercepts. This two-day Summit invited stakeholders from all regions of the State and across multiple intercepts including mental health, substance use treatment, human services, corrections, advocacy, law enforcement, health care (emergency department and inpatient acute psychiatric care), academia, and the judiciary to attend. The Summit featured presentations on innovative services and flourishing organizations in Maryland, alongside guided discussions to map Maryland's behavioral health and criminal legal system landscape. One hundred and one attendees engaged in networking and cross-disciplinary collaboration, reducing siloed work and building partnerships for future initiatives. The resulting *State Summit on Behavioral Health and the Justice System* (report) summarizes the discussions held at the 2024 Summit to further inform efforts in Maryland.

[7] Governor's Office of Crime Prevention and Policy. *Information Request*. https://docs.google.com/forms/d/e/1FAIpQLSc6TU_-krMSg16ON7ogldFqbFe4uwGnTWh-FmD41cTh14zv7w/viewform

In the next two years, the Centers aim to leverage partnerships to establish and expand crisis response and stabilization services in all Maryland counties to provide skilled and compassionate care for people experiencing behavioral health crises. The structure (law enforcement-led, clinician-led, or dual response) and size of crisis response teams will vary based on local needs and resources. The Centers will also work to establish a complete and reliable continuum of substance use disorder treatment, including medication-assisted treatment and counseling, from jails to prisons to local communities.

SUMMIT DAY ONE

Welcoming and Opening Remarks: Mr. James Rhoden, Assistant Director of the Centers of Excellence (Centers) within the Governor's Office of Crime Prevention and Policy opened the *State Summit on Behavioral Health and the Justice System* by welcoming participants and introducing Ms. Bethany Young, Director of Policy and Legislation within the Governor's Office of Crime Prevention and Policy.

Ms. Young highlighted the Centers' use of the sequential intercept model (SIM) to guide best practices, strategically shaping programs, policies, and funding initiatives to support individuals with behavioral health needs, intellectual and developmental disabilities (IDD), and neurocognitive conditions. Over the past year, priorities included workforce development, cross-system collaboration, and enhanced data sharing. This year, the Centers mapped Charles, Carroll, and Montgomery counties and initiated planning for five additional mappings. The Centers also supported crisis intervention team (CIT) efforts statewide by offering technical assistance and developing a standardized training curriculum that will soon be available for local agencies. Additionally, the Centers partnered with the University of Maryland School of Social Work and Morgan State University to undertake a statewide CIT landscape analysis to improve crisis response.

Ms. Rachel Ames and Ms. Tatiana Reyes introduced the SIM as a framework for reducing legal system involvement for individuals with behavioral health needs. Ms. Ames explained the Centers' mission to redirect individuals to health care systems, improving public health and safety. She noted that while the phrase "behavioral health needs" typically refers to mental illness and substance use, the Centers often use it as an umbrella term that includes IDD and neurocognitive conditions. Ms. Reyes emphasized the importance of diverse stakeholder collaboration, outlining the day's agenda, and highlighted the role of cross-intercept efforts in improving health and public safety responses.

Morning Presentations: Tanya Schwartz, Director of the Urgent and Acute Care Division at the Maryland Department of Health Behavioral Health Administration (BHA), shared insights from her nearly year-long tenure, emphasizing her visits to communities to assess crisis services and

observe the collaboration between law enforcement and clinicians. She highlighted the Moore-Miller Administration's significant investments in a comprehensive behavioral health continuum spanning prevention and promotion, primary behavioral health and early intervention, urgent and acute care, and treatment/recovery. Ms. Schwartz detailed initiatives to strengthen crisis services including enhancing awareness and coordination for the 988 crisis response system and Maryland's selection for a National Policy Academy to enhance services for individuals with intellectual and developmental disabilities. She announced the creation of a 988 trust fund, supported by a $3 annual fee on wireless phones and upcoming regulations for mobile crisis teams and behavioral health crisis stabilization centers, which will take effect in May 2024. BHA has allocated $14 million in supplemental funding to support these services in 19 jurisdictions. She outlined the next steps: increasing awareness of the 988 crisis line, improving 988 and 911 collaboration, supporting mobile crisis teams, licensing crisis stabilization centers, collecting data, and standardizing care. Her presentation reaffirmed the agency's commitment to advancing behavioral health services in Maryland.

John Moses, Director of Criminal Justice at Wor-Wic Community College and the Eastern Shore Criminal Justice Academy, presented the impact of crisis intervention team (CIT) training for law enforcement and correctional officers. He highlighted the 40-hour specialized training in crisis de-escalation, behavioral health, and resolution skills, emphasizing its engaging, practical approach over traditional lectures. Mr. Moses acknowledged challenges such as staffing shortages and resource constraints but noted Maryland's goal to standardize 40-hour CIT training statewide by January 2025. He stressed that CIT-trained officers, equipped with empathy, patience, and mental health awareness, can improve crisis outcomes, reduce the use of force and reliance on arrest, strengthen community partnerships, and decrease repeat encounters. To enhance these efforts, Maryland's academy curricula will introduce the critical decision-making model, emphasizing ethics, proportionality, and life preservation, alongside ongoing professional development for officers. His presentation showcased CIT training as a transformative tool in modern law enforcement.

Jennifer Corbin, Director of Anne Arundel County Crisis Response System; Lt. Steven Thomas, CIT and Peer Support[8] Coordinator of Anne Arundel County Police Department; and Judge Shaem Spencer, District Administrative Judge of Anne Arundel County's District Court of Maryland, presented a collaborative approach between crisis response, law enforcement, and the judiciary to address issues driving criminal behavior. They discussed anosognosia, a condition where individuals are unaware of their mental health issues, as a key consideration in

[8] In this report, "peer" refers broadly to individuals with shared experiences of traumatic stress, substance use, psychiatric illness, or a history of incarceration. Similarly, "peer support" encompasses various contexts, including workforce stress, incarceration, psychiatric illness, and substance use. However, the terms "peer recovery specialist" and "peer support services" specifically align with State behavioral health regulations that describe non-clinical activities provided by and for individuals in recovery from behavioral health disorders.

crisis response and highlighted the thoughtful use of emergency petitions (EPs) as a critical tool for prioritizing health over criminalization by linking individuals to care. The collaboration between crisis response, law enforcement, and the judiciary enables pre-trail release to crisis response care, ensuring stabilization and treatment before legal involvement. Pre-arrest diversion and post-arrest support were also noted as effective means to avoid detention and facilitate resource referrals. Training and reinforcement were further emphasized to reduce use-of-force incidents, alongside best practices such as addressing individuals' holistic needs and maintaining strong communication with the judiciary. The presenters encouraged enhanced stakeholder communication, program utilization, and rapport-building for successful intervention and support.

Melissa Owens, Crisis Intervention Consultant and Person with Lived Experience, also joined the Summit to share her powerful story about interactions with public safety professionals and the criminal legal system. Through her story, Ms. Owens demonstrated the importance of developing a comprehensive system that integrates community services and public safety strategies to redirect individuals to treatment services effectively. She emphasized how her county's comprehensive system played a crucial role in her diversion from the criminal legal system, ultimately preventing further negative encounters and consequences. By accessing appropriate support and resources, Ms. Owens was able to manage her mental health needs effectively, illustrating the importance of collaboration in fostering positive outcomes for individuals in similar situations.

Afternoon Presentations: Angela Shroyer, Problem-Solving Courts Coordinator for Harford County's District Court of Maryland, and Tj Humphries, Advocate, Peer Support Specialist, and Champion of Recovery at Voices of Hope, presented on a pre-screening pilot program funded by the Bureau of Justice Assistance (BJA). This program strengthens the partnership between Voices of Hope and Harford County's problem-solving courts to increase referrals to services, including Recovery Court, the Mental Health Diversion Program, and the Circuit Court Drug Court. Key objectives include diversifying referrals and reducing the time from arrest to service admission. The program's methodology involves reviewing weekly court system data to identify eligible candidates (excluding non-residents and violent offenders), maintaining a shared spreadsheet of candidates, and having Voices of Hope staff engage defense attorneys to explain the program. This partnership alleviates staffing limitations, streamlines procurement processes, and ensures ongoing peer support. Challenges include excluding violent offenders, incomplete client information, and technological barriers (e.g., client's lack of Wi-Fi or voicemail and difficulties obtaining consent over the phone). Solutions under consideration include a text-based outreach system. Data revealed that of 22,000 cases, 1,341 potential candidates were identified, leading to 16 new admissions to problem-solving courts, with all candidates

invited to peer support. The program underscores the value of cross-agency collaboration in improving service delivery and providing support.

Kristie Ardire, Pretrial Services Case Manager Supervisor for the Community Corrections Center at St. Mary's County Sheriff's Department, discussed a reentry program at the St. Mary's Adult Detention Center, active since 2015. Modeled on successful initiatives like Montgomery County's pretrial supervision program, the program was developed through stakeholder engagement and community education on the benefits of a pretrial unit. The program offers three reentry paths: 1) community corrections[9], pretrial supervision, or the day reporting program[10]; 2) in-house Medicated Assisted Treatment (MAT) and offender reentry program; and 3) in-house offender reentry. The distinction between path 2 and 3 lies in the fact that path 3 enhances the offender reentry program by incorporating MAT. Eligibility is determined through a risk assessment considering offense severity, legal status, prior convictions, court appearance likelihood, probation history, and mitigating factors like income or education. Substance use and mental health concerns may also influence release decisions. Strong partnerships with community agencies provide participants access to employment, family support, and treatment resources. Successes of the program include improved public safety, higher court appearance rates, and reduced jail costs. Challenges include staff turnover, limited housing and mental health resources, and fluctuating grant funding. Ms. Ardire emphasized the value of sustaining community relationships, adapting to changing administration priorities and maintaining a positive impact.

Annabelle Belcher, Assistant Professor of Psychiatry in the Division of Addiction Research and Treatment at the University of Maryland School of Medicine, discussed the rural opioid crisis, highlighting its status as the leading cause of injury or death in the U.S. and the higher risk of overdose fatalities in rural areas. She emphasized medication-assisted treatment (MAT) as the most evidence-based clinical approach for substance use disorders, despite its access challenges. Ms. Belcher introduced the University of Maryland's medications for opioid use disorder (MOUD) telemedicine program serving rural communities on Maryland's Eastern Shore (e.g., Talbot, Kent, and Somerset counties) and western Appalachian region (e.g., Allegany County) since 2015. The program uses vans for virtual consultations with addiction specialists and has treated thousands of patients. Recognizing the heightened risk of opioid use disorder and overdose among incarcerated individuals, the program recently expanded to offer telemedicine services in jails. Key components of the program include universal screening (including urine toxicology tests), telemedicine-based buprenorphine and methadone treatment, jail-based counseling, bridge prescriptions for reentry, and linkage to outpatient

[9] The Community Corrections Center serves as a hub for drug testing, peer support, and behavioral health services.
[10] Adult Day Reporting Center programs are highly structured non-residential programs that offer a comprehensive range of services to non-violent adult offenders as an alternative to incarceration.

treatment care upon release. This comprehensive approach aims to improve treatment access, continuity of care, and reentry outcomes for individuals with opioid use disorders in underserved rural and correctional settings.

Anne Pack, Co-Founder and Director of Advocacy of PREPARE, Inc., emphasized the critical role of early reentry planning and support for individuals transitioning from incarceration to the community. Drawing from her experience as a peer recovery specialist (PRS) and peer supervisor,[11] Ms. Pack highlighted that reentry success begins at intake and improves with ongoing assistance throughout the system and beyond. Ms. Pack outlined PREPARE's three core program engagements: 1) *PREPARE for Parole* guides individuals from intake through their parole hearing, helping them present a strong case for release; 2) *PREPARE for Home* begins six months before parole focusing on skills and preparation for community reintegration, supported by the Department of Public Safety and Correctional Services (DPSCS); and 3) *PREPARE for Success* provides ongoing follow-up post-release, with peer recovery specialists helping individuals maintain stability and achieve success in the community. The organization uses a reentry needs assessment to tailor support to each individual's needs and reentry coaches, often formerly incarcerated individuals who have successfully reintegrated into the community, to connect participants to services and provide mentorship. Many coaches transition into peer recovery specialists, deepening community integration and support. Ms. Pack highlighted PREPARE's success through education, cross-agency collaboration, and strong partnerships. She concluded by urging stakeholders to include individuals with lived experience in their practice and prioritize rehabilitation to help returning citizens successfully reintegrate and avoid re-incarceration.

Closing Remarks: Ms. Rachel Ames and Ms. Tatiana Reyes provided closing remarks for day one of the Summit by illuminating the importance of collaboration across intercepts to develop a more comprehensive understanding of how behavioral health and criminal legal systems are intertwined. The most important concept emphasized across all intercepts from day one was the critical need for collaboration at every intersection of the behavioral health and criminal legal system to improve outcomes by ensuring more coordinated, effective care and support for individuals navigating these systems to access treatment. The following section provides a brief overview of the layout of day two, outlining key sessions and topics to be covered.

[11] The term "peer recovery specialist" encompasses both credentialed and non-credentialed individuals, as does the term "peer supervisor." The Maryland Behavioral-health Professional Certification Board oversees the Maryland Certified Peer Recovery Specialist (CPRS) credential and the Registered Peer Supervisor (RPS) credential.

SUMMIT DAY TWO

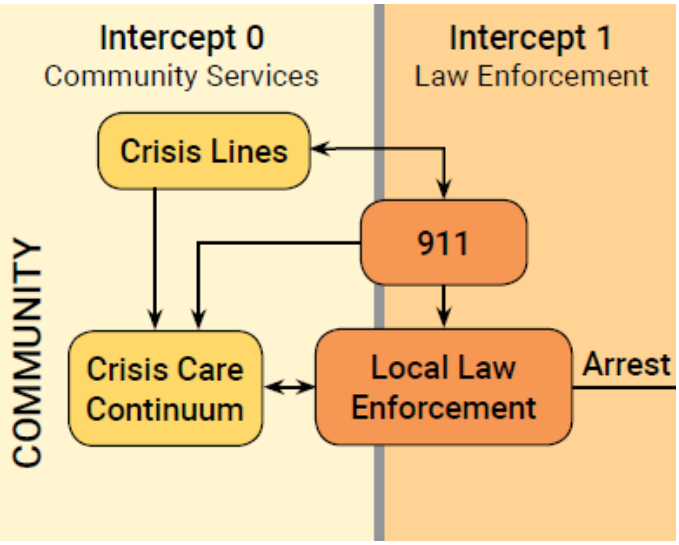
Welcoming: On day two of the Summit, Mr. James Rhoden greeted participants and Ms. Rachel Ames and Ms. Tatiana Reyes proceeded with a brief explanation of the process for SIM mapping workshops and the importance of participation in capturing an accurate depiction of the current resources and gaps within Maryland's behavioral health and justice systems.

Focus Groups: Following the welcoming remarks, participants were divided into one of three focus groups: Intercept 0-1: community services and emergency and first responders; Intercept 2-3: court diversion and jail services; and Intercept 4-5: reentry and community corrections. Each focus group consisted of two trained facilitators who led discussions to identify statewide resources, gaps in planning or programs, and action items to address identified gaps. To conclude the focus groups, participants voted to establish a list of priorities for change. After these focus group sessions, facilitators presented each list of priorities for change to all attendees. Detailed summaries of the focus group discussions and priorities begin on the following page; for a condensed overview of the priorities, please refer to the "Priorities Across Intercepts" section.

Next Steps and Closing Remarks: Ms. Ames and Ms. Reyes outlined the next steps and anticipated outcomes of the two-day convening. Ms. Reyes shared how insights from the Summit inform the Behavioral Health and Public Safety multi-year strategic plan, guide future priorities, and reduce siloed work across agencies. Ms. Ames further emphasized the need to increase awareness of SIM mapping workshops to encourage broader participation and strengthen collaborative, community-wide solutions for lasting impact. Ms. Ames and Ms. Reyes then invited Ms. Dorothy Lennig, Executive Director of the Governor's Office of Crime Prevention and Policy, to offer closing remarks.

Ms. Lennig reiterated the importance of gathering as a group to guide strategic planning and policy-making. She further encouraged counties that have not yet completed or scheduled a mapping to bring insights from the Summit back to their communities to inspire local collaboration and request a mapping. Ms. Lennig reassured attendees that the Centers provide seamless guidance in planning the workshops and producing a comprehensive report to support each community's efforts. To close, Ms. Lennig thanked participants for attending and encouraged them to stay for networking opportunities.

Intercepts 0 and 1



Resources

Promotion and Prevention: Maryland's vision for a behavioral health continuum of care starts with resource promotion and a combination of universal, selective, and indicated prevention.[12] Several agencies and programs exist to provide support and resources for Maryland communities.

- The Maryland Department of Human Services (DHS) supports residents in economic need by helping them access healthy food, pay energy bills, and obtain medical assistance.
- Each jurisdiction has a local health department promoting the use of existing programs for food, health, housing, transportation, education, employment assistance, and more.
- The 211 Maryland (211) program is a free, confidential statewide resource line that operates 24/7. By selecting Option 4, users can access referrals for emergency department patients requiring community-based behavioral health services, including support for mental health conditions, substance use disorders, and developmental disabilities.

[12] The Institute of Medicine (IOM) Classification System classifies prevention interventions according to their target population. The IOM identifies the following three categories based on level of risk: universal, selective, and indicated. Universal interventions target the general population and are not directed at a specific risk group. Selective interventions target those at higher-than-average risk for substance abuse. Indicated interventions target those already using or engaged in other high-risk behaviors to prevent heavy or chronic use.

- Schools and libraries provide unique access to families and often serve as community hubs.
- The community resources available for specialty populations vary by geographic location and need.
- The Brain Injury Association of Maryland provides advocacy, education, and research to support individuals, families, and professionals.
- PFLAG, the nation's largest organization dedicated to supporting, educating, and advocating for LGBTQ+ people and their loved ones, operates eight PFLAG chapters throughout Maryland. There are also five LGBTQ+ support centers operating statewide.
- Within the Maryland Department of Health (MDH) Behavioral Health Administration (BHA), the Maryland's Commitment to Veterans program develops policy and programming while also providing direct services. This office coordinates with national, state, and local organizations; provides referral services, peer support, and crisis funding to Maryland service members, Veterans, and their families; and offers training/educational opportunities for behavioral health and medical providers, peers, first responders, and community partners.

Community-Based Services: Various types of community-based behavioral health services are available statewide.

- All Maryland residents can register for a free grant-funded course in Mental Health First Aid, a curriculum developed by the National Council for Behavioral Health to effectively train individuals (including criminal justice professionals) to recognize behavior commonly associated with mental illness. For more information, please find the course at: https://www.mentalhealthfirstaid.org/.
- Several dedicated organizations provide behavioral health peer support in Maryland.
    - Nonprofit organizations such as NAMI Maryland, On Our Own of Maryland Inc., and the Depression and Bipolar Support Alliance provide education, support, and advocacy for persons with mental illnesses, their families, and the wider community; local chapters offer free, peer-led support groups.
    - People and families with a loved one experiencing challenges related to mental health, substance use, or problem gambling can access peer support through nonprofit organizations such as the Maryland Coalition of Families, Alcoholics Anonymous, Narcotics Anonymous, Al-Anon Family Groups, and Nar-Anon Family Groups.
    - Through funding from the Maryland Behavioral Health Administration, a network of peer-led wellness and recovery centers (WRCs) are operated across the State as part of the Maryland Public Behavioral Health System (PBHS) continuum of care. WRCs offer resources, socialization, and activities within the context of a community of peer support.

- Outpatient and early intervention services are available in primary care settings in every jurisdiction.
- Mobile treatment programs provide recovery-focused, high-intensity, community-based treatment and support in non-office settings for people with serious and persistent mental illnesses.
    - Assertive community treatment (ACT) is a client-centered, community-based mental health service model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation, and recovery for persons who have the most severe and persistent mental illnesses and have not benefited from traditional outpatient programs. Community providers refer clients to ACT teams that work with clients in their homes, neighborhoods, and community locations, providing on-call phone support 24 hours a day, 7 days a week. ACT teams are available in 19 counties; residents of Caroline, Kent, Somerset, Talbot, and Worcester counties must travel outside their jurisdiction for this service.
    - Many communities deploy strategies to target high-utilizing, vulnerable populations. These strategies include Maryland's EMS Naloxone Leave-Behind program (operational in all counties except Allegany, Calvert, Dorchester, Queen Anne's, Somerset, and Talbot) and mobile community health care programs (e.g., Community Outreach And Support Team (COAST) in Frederick County and Mobile Integrated Health (MIH) in Montgomery County.)

Urgent and Acute Care: Maryland's blueprint for a vibrant behavioral health continuum of care includes urgent and acute care services offering, in lay terms, someone to call, someone to respond, and somewhere to go.

- State residents may access various warmlines and hotlines to prevent or handle crises.
    - The 988 Suicide and Crisis Lifeline ("988 Lifeline") is available 24/7 in English and Spanish by call, text, or web-based chat with a goal of live response within 25 seconds. For individuals who communicate through sign language, a video chat option is available. Additionally, voice calls can be translated into over 240 languages through Language Line Solutions. Calls to the 988 Lifeline are routed to a local crisis center with counselors who can provide referrals to local services; 988 counselors can transfer to 911 when necessary. Every jurisdiction receives grant funding that allows the 988 Lifeline to be operational statewide.
    - The Veterans Crisis Line and Military Crisis Line are available 24/7 regardless of VA enrollment to military-connected individuals and their loved ones; services are available by call (988 option 1), text (838255), or web-based chat.
    - The Crisis Text Line can be accessed 24/7 by texting "home" (or "ayuda" for services in Spanish) to 741741 or via WhatsApp.

    - The National Domestic Violence Hotline (800-799-7233) is also available 24/7 by call, text, or chat. The Maryland Network Against Domestic Violence maintains a directory of programs that offer 24-hour hotlines, access to shelter, counseling, and advocacy; these services are available statewide.
    - The Human Sex Trafficking Hotline (888-373-7888) is available 24/7 by call, text, or chat with interpreters available (call only). Additionally, tips can be submitted online through an anonymous online reporting form.
    - The NAMI HelpLine (800-950-NAMI), is a free, nationwide peer-support warmline accessed by call, text, or chat between 10 a.m. and 10 p.m.
- Mobile crisis teams and crisis intervention teams provide crisis intervention and follow-up services.
    - Mobile crisis services provide no-cost, immediate, on-site behavioral crisis intervention and debriefing services via a civilian pair including at least one clinical professional. Models for mobile crisis teams vary; some mobile crisis teams utilize police radios and are directly dispatched, while others are dispatched at the request of law enforcement on the scene. Mobile crisis teams currently operate in all jurisdictions with varying service hours.
    - The crisis intervention team (CIT) model is designed to center consumer, officer, and community safety in law enforcement responses. The model proposes a community partnership that includes law enforcement training, community collaboration, a vibrant and accessible crisis system, behavioral health staff training, and community education. Implementation strategies vary, but jurisdictions are funded statewide. Programs that facilitate collaboration between law enforcement and partners to connect community members to care are aligned with the CIT model even if not formally identified as such. The CIT model is discussed in more detail on the following page.
- Behavioral health walk-in and urgent care centers provide on-demand behavioral health services. Urgent care centers offer same-day or next-day appointments, while walk-in centers do not require appointments.
    - All but three counties (Prince George's, Somerset, and Wicomico) offer at least one of these services.
    - Behavioral health urgent care centers are located in 14 jurisdictions; three of those jurisdictions offer weekend appointments. Behavioral health walk-in centers are located in nine jurisdictions. Four of those jurisdictions offer weekend access while another three are available around per day, seven days per week.
- Crisis stabilization services include 23-hour behavioral health crisis stabilization center (BHCSC) services and residential crisis services (RCS). BHCSC services are available in 15 jurisdictions; five of these 15 locations accept walk-in clients, while the remainder are

available by referral. RCS programs provide short-term mental health treatment and support services in a structured environment for uninsured or PBHS-insured individuals who require 24-hour support due to a psychiatric crisis; programs intend to prevent psychiatric inpatient admission, shorten the length of inpatient stay, effectively utilize hospital emergency departments, and provide an alternative to psychiatric inpatient admission. These services are available in 17 jurisdictions.

- Inpatient psychiatric care (voluntary or involuntary) is reserved for those individuals who meet admission criteria. Capacity varies widely within and across jurisdictions. The Behavioral Health Hospital Coordination Program tracks available beds in real-time to display on the inpatient psychiatric bed board accessible at: https://health.maryland.gov/bha/Pages/hospitalcoordination.aspx.

Law Enforcement Response: Section 3-517 of the Public Safety Article requires local law enforcement agencies to adopt a community policing program that follows best practices from the Maryland Police Training and Standards Commission (MPTSC). Community policing strategies vary across communities and may include crisis intervention teams.

- The crisis intervention team (CIT) program provides a strong foundation for law enforcement to respond to individuals experiencing a behavioral health crisis; it also serves as a precursor for implementing broader strategies to integrate public safety and behavioral health systems.
- The co-responder framework typically features a specialty team that includes at least one law enforcement officer and one mental health or substance use professional responding jointly to behavioral health calls; teams may be directly dispatched (primary co-response) or dispatched at the request of law enforcement on the scene (secondary co-response). Team members may ride in the same vehicle, arrive at the scene separately, or co-respond remotely via phone or telehealth support. Variations on the co-responder model include referral programs and multi-professional teams.
- In referral programs, officers refer community members to services. Many Maryland programs using this model employ a behavioral health liaison embedded within law enforcement agencies or utilize the local behavioral health authority to handle referrals. Notably, EMS provides direct referrals in some locations.
- A multidisciplinary team in Frederick County comprising a plain-clothes officer, an EMT, and a mental health specialist (clinician or paraprofessional) responds in an unmarked vehicle known as the Crisis Car. The Crisis Car only operates in Frederick City and does not have transport capability. While hours are currently limited to weekdays, the program intends to expand to include evenings and weekends.
- Police-led diversion initiatives include the Law Enforcement Assisted Diversion (LEAD) program and the Safe Station model.

    - LEAD connects police directly to service providers who respond immediately to assist individuals identified by police. There are 16 active LEAD sites statewide including a multi-jurisdictional program operated by the Office of the Public Defender. The Governor's Office of Crime Prevention and Policy currently administers the Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) fund to 13 of the 16 active LEAD sites.
        - In Carroll County, the Quick Response Team (QRT) is an expansion of the local Law Enforcement Assisted Diversion (LEAD) program and a secondary response to overdose survivors who refuse transport to the hospital; a portion of LEAD referrals are generated through QRT responses. The LEAD/QRT team may access law enforcement radio channels to facilitate communication.
    - The Safe Station model allows individuals to seek assistance from police for substance use disorders without fear of arrest or prosecution by offering 24/7/365 entry points to treatment for substance use; programs are operating in the following counties: Anne Arundel, Caroline, Talbot, Wicomico, and Worcester. In some programs, individuals seek care directly, while in others, officers can refer individuals for follow-up by a peer professional. Of note, some jurisdictions have successfully expanded this police-led diversion program by including fire stations and community organizations as additional entry points outside of police stations.
- Established by Section 2-412 and Section 4-1501 through 4-1504 of the Public Safety Article, P.R.O.T.E.C.T. (Public Resources Organizing to End Crime Together) is a program designed to combat neighborhood decline by supporting comprehensive strategies aimed at reducing crime and fear in affected communities. The program ensures that local law enforcement is utilized in direct public safety roles. Legislation requires the deployment of ten P.R.O.T.E.C.T. Coordinators embedded within local law enforcement agencies operating in high-crime microzones. These jurisdictions include Allegany County, Anne Arundel County, Baltimore County, Baltimore City, Cecil County, Dorchester County, Frederick County, Prince George's County, Washington County, and Wicomico County.[13]
- Training is an essential component of a successful community policing program. Dispatchers can access both CIT and Mental Health First Aid training when available.
    - Integrating Communications, Assessment, and Tactics (ICAT) training through the Federal Emergency Management Agency (FEMA) Center for Domestic Preparedness provides a free 12-hour training developed by the Police Executive Research Forum (PERF) to address patrol officer response to non-firearm

[13] As of publication, the P.R.O.T.E.C.T. Coordinator for Prince George's County is vacant.

incidents with a focus on the integration of crisis recognition and intervention, communications, and tactics; ICAT also offers a 4-hour train-the-trainer module. This training is suitable for both police and corrections. Agencies can apply to train staff free of charge; the Eastern Shore Criminal Justice Academy has trained 45 instructors through grant funding.

Workforce Wellness: Worker well-being relates to quality of life regarding personal health and work-related environmental, organizational, and psychosocial factors. The importance of this integrative concept applies equally to health professionals and first responders.

- Focused support for first responder safety and wellness is an essential element of public safety, playing a crucial role in the well-being of professionals and their colleagues, agencies, families, and communities. First responders require resources that are well-versed in public safety operations.
- The National Law Enforcement and First Responder Wellness Center at Harbor of Grace is a unique program providing mental health and substance use treatment exclusively for first responders.
- Safe Call Now (206-459-3020) is a confidential, comprehensive, 24/7 crisis referral service for all public safety employees, all emergency services personnel, and their family members nationwide.
- First responders require specialized training and outreach efforts to ensure holistic wellness strategies are understood and implemented. Existing training for first responders in Maryland includes topics such as stress, trauma, adverse childhood experiences (ACES), and first responder vulnerability; solutions to mitigate these challenges are a necessary focus of a wellness program.
- Officer assessments provide an opportunity to suggest resources one-on-one.
- Peer support plays a crucial role in first responder wellness. Champions within departments can link fellow first responders to local services.
- Critical incident stress management (CISM) teams assist first responders in mitigating and responding to the normal emotional and psychological effects of responding to critical incidents. Most fire/EMS and law enforcement departments now have their own local CISM and/or peer support teams; the Maryland Institute for Emergency Medical Services Systems (MIEMSS) covers the remaining small pockets, most of which are located in the western region of Maryland. MIEMSS operates a 24/7 toll-free number to connect callers to local teams or MIEMSS resources; this number is printed on all Maryland EMS licenses. There is an opportunity to develop local CISM teams in each jurisdiction through professional training through the International Critical Incident Stress Foundation Inc. (ICISF).

- CIT Coordinators and Wellness Coordinators around Maryland support first responder wellness by connecting individuals to resources and orchestrating wellness events to encourage health and reduce stigma.
- Agencies promote and, when possible, incorporate successful strategies from around the country. The National Law Enforcement Officers Memorial Fund 2024 National Officer Safety and Wellness Awards highlight two agencies from Maryland and the National Capital Region: The Baltimore City Police Department has been recognized for its robust Officer Safety and Wellness department, while the Fairfax County Police Department and Fire and Rescue Department have been recognized for their cutting-edge Fairfax County Public Safety Wellness Center.

Gaps

Promotion and Prevention: Statewide, many community resources remain underutilized due to a lack of awareness of the full array of services and the criteria to utilize them. Further, with crisis system definitions in flux and the crisis continuum expanding, community members and stakeholders across Maryland would benefit from improved communication and consistency in terminology.

- The Maryland Behavioral Health Network of Care could be streamlined to be more user-friendly and promoted to the community.
- External resource hubs like Findhelp (findhelp.org) are frequently already known to the public and exist to build software that supports collaboration across the public and private sectors. Notably, Findhelp can be embedded into EPIC (a cloud-based electronic health records (EHR) system that helps health care providers manage patient information) for an integrated treatment referral process.
- Non-traditional partners require intentional outreach to ensure that programs are promoted.

Community-Based Services:

- When it occurs, the failure to include community-based organizations in listening sessions and town halls represents a missed opportunity to expand capacity.

Urgent and Acute Care:

- Stabilization services vary by community; significant funding disparities contribute to the lack of crisis resources in underserved areas.
- Reinvestment of hospital diversion savings can expand urgent care and further diversion capacity while building a robust continuum of care. Currently, existing urgent care options vary by location (embedded in hospital or independent) and admission criteria (mental health, substance use, or co-occurring concerns).

Law Enforcement Response:

- There is a growing chorus of voices requesting updates to emergency petition (EP) policy and procedure. The current process lacks an evidence-based standard statewide and is a source of frustration for law enforcement professionals who cite outdated forms, unclear regulations, and confusion regarding the use of force. Professionals are increasingly expressing interest in creating a workgroup or committee to drive EP reform in Maryland.
    - Additional training by behavioral health liaisons and other professionals for law enforcement and hospital personnel may address some known concerns. Officers must be clear on the process and their role in it; hospital staff must be informed of what appropriate law enforcement responses may and may not include. Miscommunications lead to refusals to serve or accept EPs on the part of law enforcement, hospital, and security staff.
    - Daunting capacity concerns and burnout plague professionals in intercepts 0 and 1, fueling the hesitancy to serve or accept EPs.
    - Sections 10-601 and 10-624 of the Health General Article authorize a petition for emergency evaluation to be in the form of an electronic record and transmitted and received electronically; however, jurisdictions are awaiting guidance regarding implementation. Since agencies require a physical document to serve an EP, there is currently no efficient way to execute this process across jurisdictions. Any updates to the form must take place through the district court.
    - Lack of transportation leads to unnecessary EPs; individuals willing to seek voluntary treatment may alter their responses to meet the criteria for an EP when transportation is a barrier to assessment and treatment.

Workforce Development: Workforce development relies on hiring and retaining qualified staff to meet demand effectively.

- Wellness is an essential component of retention. Burnout resulting from chronic workplace stress can have physical and emotional effects on individuals, negatively impact interactions with consumers, and disrupt system operations.
- Staffing shortages impact agencies statewide.
- Incentivising work in acute care settings is challenging given the disparity between civil salaries and private contracts.
    - Notably, there is an opportunity to collaborate with academic institutions to develop a pipeline that provides upward mobility and reduces the cost of entry into the professional workforces facing staffing shortages.
    - The Substance Abuse and Mental Health Services Administration (SAMHSA) has recently launched the Behavioral Health Workforce Career Navigator to help

current and aspiring behavioral health professionals identify State requirements for a range of behavioral health careers.

- Officer wellness continues to be a concern.
    - Siloed officer wellness resources hamper accessibility. The creation of a statewide directory can help to address this barrier. Maryland State Police is reportedly identifying public safety-fluent providers in each jurisdiction, which could serve as a component of this proposed resource.
    - Professionals working with first responders and emergency personnel have access to several cultural competence trainings and certifications (e.g., Certified First Responder Counselor). However, there are currently no state licensure requirements for this specialized training.
    - Training across the crisis continuum is needed to improve competency with first responder culture; policies and procedures that support first responders (i.e., separate entrances for treatment access) vary widely.
    - Anti-stigma efforts are essential to encourage first responders to seek help.
        - The Maryland CIT Statewide Conference, which was halted due to the COVID-19 pandemic, has not yet resumed despite widespread support for an event that promotes officer wellness and anti-stigma efforts.
        - There is an opportunity to request that officer wellness be included in the Maryland Chiefs of Police Association and the Maryland Sheriff's Association's meeting agendas.
        - Officer wellness can also be included at the annual Maryland Chiefs of Police Association / Maryland Sheriffs' Association Professional Development Training Seminar & Exhibitor Shows.
    - Legislation such as Section 4-1012 of the Public Safety Article was established to support CISM peer support training; however, no mandated funding was attached to the legislation, which is reliant on available budget allocations.

Coordination: System-wide responsiveness is limited by gaps in cross-agency coordination; silos inhibit progress. Data sharing and program evaluation are hindered by inadequate technical infrastructure and inconsistent metrics; however, these issues are complicated by cross-jurisdictional differences. These differences exist at the county, region, and state levels.

- 988 is still developing as an integrated crisis resource. Nationally, 988 routes calls using geo-routing rather than geolocation; in instances where callers use a wireless carrier for which geo-routing is not active, individuals are assigned to call centers based on area code rather than physical location. The coordination between 911 and 988 varies across contracted providers. MOUs are needed to facilitate bidirectional transfers.
- Coordination between hospitals and their partners is an area of concern. Stakeholders are unclear on the relationships between the resources that exist both inside and

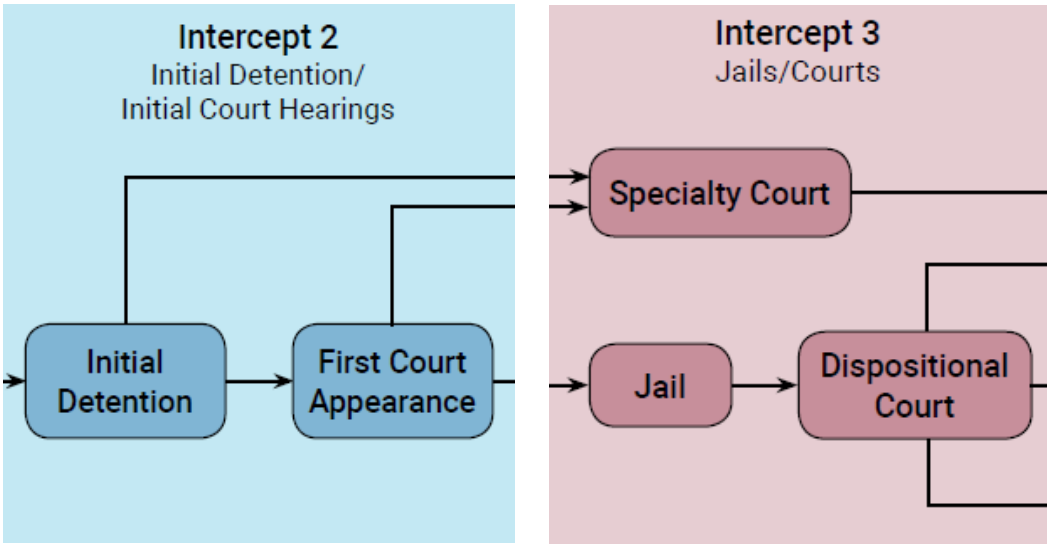
outside hospital settings (e.g., peer professionals). Further, hospital behavioral health capabilities and capacity vary widely. As a result, community members frequently work around a system rather than within it; for example, people often travel outside their local communities to be directly admitted rather than face the challenges associated with transfers. There is an opportunity for developing a best-practice protocol based on a statewide scan.

- Sharing fire/EMS and law enforcement data is uniquely challenging due to data misalignment between entities, data suppression, and privacy restrictions.
    - A universal streamlined data sharing platform would allow for enhancements of statewide data dashboards; while the new Overdose Data Dashboard managed by Maryland's Office of Overdose Response (MOOR) has reduced the data release period from 90 to 30 days, expansion of current efforts (including increased staffing) could allow for data to be released daily for the most proactive monitoring and response capabilities. Under the Overdose Data to Action program ("OD2A"), the Centers for Disease Control funds the expansion of drug overdose surveillance and prevention efforts in 90 health departments across the country; the Baltimore County Department of Health has received funding locally ("OD2A: LOCAL"), while MDH has received statewide funding ("OD2A in States") for a six-jurisdiction pilot program.

Intercepts 0-1 Priorities

1.	Ensure equitable funding of crisis services, including mobile crisis and stabilization services.	19 votes
2.	Enhance first responder wellness.	14 votes
3.	Explore emergency petition reform.	12 votes
4.	Enhance hospital collaboration with partners in health care, public safety, and community services.	7 votes
5.	Develop a behavioral health workforce pipeline.	7 votes
6.	Expand service access and provider choice across the behavioral health continuum of care.	2 votes
7.	Facilitate data and information sharing for continuity of care.	2 votes

Intercepts 2 and 3



Resources

Diversion linkage programs are designed to connect individuals to community-based treatment and support services as an alternative to formal prosecution or incarceration. These programs typically operate at various points in the process, such as pre-arrest, post-arrest, or during court proceedings, and aim to address the root causes of criminal behavior by addressing health and social service needs.

- Law Enforcement Assisted Diversion (LEAD) programs (described in the "Intercepts 0 and 1" section) provide pre-arrest diversion opportunities to low-level offenders with behavioral health needs, redirecting them to case management and services instead of entering the criminal legal system.
- The Stop, Triage, Engage, Educate, and Rehabilitate (STEER) program in Montgomery County partners police with care coordinators to quickly link individuals to treatment and support rather than processing them through the legal system. This program primarily serves those with lower-risk, non-violent offenses, offering an effective way to address the root causes of criminal behavior while reducing recidivism.
- The Maryland Office of the Public Defender receives referral requests from prosecutors for diversion at bond review hearings.

Screenings and assessments are utilized at various stages in the criminal legal system to evaluate risks, needs, and mental health status. Screenings and assessments are distinct processes; screenings serve as quick, broad tools to identify potential issues, while assessments

involve in-depth evaluations to understand the specific nature, cause, and severity of a problem.

- Risk and Need Triage (RANT) is an evidence-based program that provides supervision and clinical service recommendations. It has been demonstrated as an effective triage tool for drug-involved individuals at or near the point of arrest to determine disposition, meaning the most appropriate course of action or outcome, such as diversion to treatment, further legal processing, or other interventions.
- Pre-screening pilot programs are established in Harford, Cecil, and Caroline counties to screen individuals charged with non-violent offenses. These programs aim to identify risks and needs related to substance use and mental health before hearings, intending to increase referrals to community-based services and reduce the processing time between arrest and admission to necessary treatment services.
- Validated risk assessment tools are available for the booking process across all jurisdictions.
- Mental health and substance use screening is available at booking in select counties and is often done independently.

Pretrial services are programs or agencies that support the criminal legal system by providing supervision, support, and resources to individuals released from custody while they await their trial. The goal of pretrial services is to promote public safety, ensure that individuals return to court for their scheduled appearances, and reduce unnecessary detention of individuals who may be safely managed in the community.

- Pretrial services are available in all jurisdictions.
- Formal pretrial units, however, are only established in select counties.
- Notably, the demand for pretrial services varies across jurisdictions.

Problem-solving courts are specialized courts within the criminal legal system designed to address the underlying issues—such as mental health disorders, substance use, homelessness, or trauma—that contribute to criminal behavior. These courts aim to reduce recidivism and improve individual outcomes through a collaborative, treatment-focused approach rather than traditional punitive measures.

- There are 69 problem-solving courts in 23 of the 24 jurisdictions in Maryland.
- Types of problem-solving courts include Adult Drug Courts, Mental Health Courts, Veterans Treatment Courts, Reentry Courts, Truancy Courts, Family Recovery Courts, Juvenile Drug Courts, and Back-on-Track Courts.
- The courts' coordinators directory can be found online at: https://www.mdcourts.gov/sites/default/files/import/opsc/pdfs/coordinatorslist.pdf. However, please note that some coordinators staff multiple courts; therefore, while all

courts have a coordinator, the total number of listed coordinators does not reflect the total number of courts.

- Criteria for participation in problem-solving courts vary based on the specific focus of each court, addressing distinct needs and often considering factors like offense type, criminal history, risk level, and willingness to engage in treatment.
- The time between identifying possible participants for drug courts and entering drug courts varies, but the goal statewide is 7-14 days.
- Key characteristics of problem-solving courts include an emphasis on therapeutic interventions, regular court appearances and monitoring tailored to each participant's progress and needs, a collaborative team approach, and accountability.
- Some jurisdictions without formalized courts have established informal specialty dockets to manage specific cases (e.g., a Mental Health Docket). These dockets often comprise a team committed to working on specialty cases in addition to regularly scheduled cases.

Court-ordered services are interventions or treatments mandated by a court as part of an individual's sentence, probation, pretrial release, or diversion program. These services are intended to address underlying issues that may contribute to criminal behavior and improve the individual's chances of successful reintegration into the community. Court-ordered services are used across jurisdictions.

- Competency Evaluations: The Maryland Department of Health conducts competency evaluations in person and virtually depending on the defendant's bond status. If, after a hearing, the court finds that the defendant is incompetent to stand trial but is not dangerous to the defendant or others, the court may set bond conditions for the defendant or authorize the release of the defendant on recognizance. If, however, the court finds that the defendant is incompetent to stand trial and is a danger to the defendant or the public, the court orders the defendant committed to a facility designated by the Maryland Department of Health until the court determines that the defendant no longer is incompetent to stand trial; the defendant no longer meets the standard of dangerousness; or there is not a substantial likelihood that the defendant will become competent to stand trial in the foreseeable future.
- Petitions for Emergency Evaluation: Mental health professionals (e.g. physicians, psychologists, clinical social workers), law enforcement, and anyone interested in an individual's mental well-being may file an emergency petition. If a judge grants a petition for emergency evaluation, law enforcement will take the individual to an emergency facility for rapid evaluation. However, emergency facilities may only keep an individual who is emergency petitioned for up to 30 hours unless a physician or a psychologist completes certificates for involuntary admission. Involuntary admission may only be deemed when an individual has a mental disorder, is a danger to themselves or others, unable or unwilling to be admitted voluntarily, and there is no less restrictive form of

care or treatment to meet the individual's needs. Considerations related to current policy and procedure are described in the "Intercepts 0 and 1" section.

- Assistant Outpatient Treatment[14]: Sections 10-6A-01 through 10-6A-12 of the Health General Article authorize (not require) counties to establish assisted outpatient treatment (AOT) programs. These programs provide court-ordered treatment for individuals with severe mental illness who meet specific criteria, such as a history of non-compliance with treatment that has led to hospitalization or incarceration. All jurisdictions must determine whether they will be establishing AOT independently or with the assistance of MDH by early 2025.
- Health General Commitment Evaluation[15]: Sections 8-505 and 8-507 of the Health General Article allow for court-ordered evaluations for drug or alcohol use. These orders are valuable resources for addressing substance use or co-occurring diagnoses, offering specialized support, and integrated care for individuals with multiple conditions. These evaluations can be ordered at all stages of the criminal proceedings.

Training opportunities are essential for professionals working in initial detention, first court appearances, jail, and courts, to equip staff with the skills and knowledge to identify behavioral health needs early on, allowing for more informed decisions and opportunities to redirect individuals toward appropriate treatment and support systems.

- Personnel can receive crisis intervention team (CIT) training, mental health first aid (MHFA) training, and trauma-informed training.
    - Correctional officers may receive the 40-hour CIT training, but percentages vary in every jurisdiction.
    - Most providers and parole and probation agents participate in MHFA training.
    - Trauma-informed care training is provided for problem-solving court staff.
- The New Trial Judge Orientation Program in Maryland is a three-phase program for newly appointed judges, including courses covering implicit bias and communication skills training.
- The Judicial College of Maryland and the Maryland Department of Public Safety and Correctional Services offer opportunities for continuing education.

Health care and rehabilitation services within correctional facilities are crucial for addressing the physical and mental health needs of individuals who are incarcerated, as they provide essential support and treatment that can significantly improve outcomes. Similarly, access to remote and in-person hearings supports rehabilitation by facilitating timely legal proceedings.

[14] §10–624(b) of the Health-General Article: https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=ghg&section=10-624&enactments=False&archived=False

[15] Certification Manual: HG § 8-507 Court Ordered Treatment: https://health.maryland.gov/bha/Documents/12.18.2017%20MDH%208-507%20Providers%20Manual%20(5).pdf

- WellPath is contracted by many correctional facilities for medical and mental health care, but vendors for prescription services vary across jurisdictions. Some jurisdictions may also collaborate with different local health departments and pharmacies based on specific needs and contractual agreements.
- Correct Rx Pharmacy Services, Inc. has been contracted by the Department of Public Safety and Correctional Services for prescription services within correctional facilities across the State through 2024.
- In compliance with sections 9-603 of the Correctional Services Article Correctional, correctional facilities must assess the mental health and substance use status of each incarcerated individual using evidence-based screenings and assessments. Facilities are required to provide one of the three FDA-approved medications for opioid use in conjunction with counseling services and reentry planning while incarcerated. All 24 jurisdictions are offering some form of medication for opioid use disorders as of October 2024.
    - The Research, Analysis, and Evaluation division within the Governor's Office of Crime Prevention and Policy regularly updates the Opioid Use Disorder Examinations and Treatment Dashboard[16] publicly accessible on the Office's website.
    - The Justice Reinvestment team within the GOCPP provides an Opioid Use Disorder Examinations Treatment Reporting Guide[17] and Reporting Template[18] on the Office's website.
- The Chesapeake Regional Information System for our Patients (CRISP), Maryland's designated Health Information Exchange (HIE), is a database that enables the secure sharing of health information among doctors, hospitals, labs, and other health care organizations. It supports safer, more efficient, patient-centered care for individuals who do not opt out and whose providers participate. CRISP is utilized across intercepts to prevent medication duplication and diversion.
    - Summit participants noted that the Mid-Shore regularly uses this tool in intercepts 2 and 3 to track medication and avoid pharmacy hopping/shopping.
- Resources vary by facility but generally include the following programs/services:
    - General Educational Development (GED) courses
    - Counseling services

[16] Opioid Use Disorder Examinations and Treatment Dashboard. https://gocpp.maryland.gov/data-dashboards/opioid-use-disorder-examinations-and-treatment-dashboard/
[17] Opioid Use Disorder Examinations and Treatment Reporting Guide. https://gocpp.maryland.gov/wp-content/uploads/Opioid-Use-Disorder-Examinations-and-Treatment_-Data-Definitions-and-Reporting-Guide-Revised.pdf
[18] Opioid Use Disorder Examinations and Treatment Reporting Template. https://gocpp.maryland.gov/wp-content/uploads/Opioid-Use-Disorder-Examinations-and-Treatment-Reporting-Template-Updated-5_24.xlsx

    - Professional development services
    - Drug and alcohol classes
    - Faith-based services
- Additional resources identified in some facilities include:
    - Parenting courses
    - Anger management courses
    - Full-service libraries
    - Tablets and other accessible technology
- Facilities continue to offer remote hearings following the COVID-19 pandemic, but in-person hearings are encouraged and preferred when possible.

Peer support in the criminal legal system involves individuals with lived experiences helping those currently navigating legal challenges. This support fosters trust and connection, empowering individuals to make informed decisions and facilitating their reintegration into society after incarceration.

- Access to peer support/certified peer support specialists varies at different points of the system and across the State.
- Peer support and certified peer support specialists are available in many jurisdictions.

Advisory bodies play a crucial role in improving the behavioral health and public safety system by bringing together experts, stakeholders, and community representatives to evaluate policies, address service gaps, and recommend best practices. Their collaborative efforts promote coordinated responses, enhance access to treatment, and ensure that policies adapt to community needs.

- Statewide task forces and commissions include:
    - Commission on Behavioral Health Care, Treatment, and Access (MDH)
    - Commission on Correctional Standards (DPSCS)
    - Correctional Training Commission (DPSCS)
    - Opioid Operational Command Center
    - Task Force to Study Transparency Standards for State's Attorneys (DLS)
    - Racial Disparities in Overdose Task Force (ext. of the Inter-agency Opioid Coordinating Council)
- Statewide councils and boards include:
    - Behavioral Health Advisory Council (MDH)
    - Correctional Education Council (DL)
    - Criminal Justice Coordinating Council (GOCPP)
    - Inter-agency Opioid Coordinating Council (Office of Overdose Response)
    - Justice Reinvestment Oversight Board (GOCPP)
    - Maryland Correctional Enterprises Management Council (DPSCS)

    - State's Attorney's Coordination Council
- Many jurisdictions have advisory bodies that advance initiatives, and it is essential for these entities to facilitate collaboration, minimize duplication of efforts, and build upon positive outcomes.

Gaps

Diversion Programs:

- Diversion is only successful if there are enough resources available in the community to which court personnel can refer.

Screenings and Assessments:

- Jurisdictions must build the capacity to perform additional functions and bridge service gaps such as providing more screenings and comprehensive assessments.
- Uniform screening for Veteran status is absent; Commissioners are now allowed to ask individuals for Veteran status which assists with response and referrals.
- Mental health and substance use screening and assessment tools and processes are inconsistent across jurisdictions.
    - Differentiating between individuals with mental health problems and those with serious mental illness[19] would improve service effectiveness.
- Assessments are valid for a limited amount of time (i.e. substance use assessments are invalid after 30 days).

Pretrial Services:

- Public defenders and parole and probation agents often provide pretrial services due to a lack of formal units; however, they cannot provide pretrial supervision.
- Pretrial services and units are not overseen by a single state entity; instead, each jurisdiction is responsible for managing its pretrial operations.
- Pretrial screening tools and processes are inconsistent across jurisdictions. The pretrial phase can involve significant delays as there are various approaches to handling pretrial decisions.

[19] Under Maryland Regulation § 10.21.17.02, serious mental illness is defined as a mental disorder occurring in individuals aged 18 or older. It includes diagnoses such as schizophrenia, major affective disorders, other psychotic disorders, or borderline or schizotypal personality disorders, excluding abnormalities solely manifested by repeated criminal or antisocial conduct. SMI is further characterized by impaired functioning, either continuously or intermittently, for at least two years, and is identified by at least three of the following criteria: 1) inability to maintain independent employment; 2) social behavior that results in interventions by the mental health system; 3) inability, due to cognitive disorganization, to procure financial assistance to support living in the community; 4) severe inability to establish or maintain a personal support system; or 5) need for assistance with basic living skills.

- Delays in the referral process create barriers to substance use treatment; as individuals frequently become ineligible by the time the referral is received. This delay underscores the importance of initiating the process earlier to ensure eligibility for treatment.
    - To address this issue, case managers can play a crucial role by ensuring referrals are submitted on time, improving the chances that individuals meet the criteria for treatment.

Problem-solving Courts:

- Problem-solving courts have eligibility requirements; these courts may not serve individuals with co-occurring disorders and only take individuals with certain levels of risk.
- There is a lack of formally established mental health courts; current established court services have limited diversion options for individuals with serious mental illness.
- Since individuals cannot cross jurisdictions to attend problem-solving courts, the lack of cross-jurisdictional health care coordination can make it difficult to access the necessary treatment services and support required by these courts in under-resourced jurisdictions. Summit participants recommended that the State evaluate the infrastructure of courts and provider treatment and referral systems to determine whether strict limitations based on county residency or county boundaries are necessary.

Training:

- Some correctional facilities lack sufficient officers with 40-hour CIT training certification.

Workforce Challenges and Stability:

- Cross-system coordination and communication are needed as familiarity with resources and providers enhances service delivery and outcomes.
- High turnover and transition of roles contribute to staffing shortages.

Services within Correctional Facilities:

- Remote options and technology-based services may be challenging in correctional facilities due to inconsistent internet access, which can disrupt their effectiveness.
- Mental health services within correctional facilities vary; generally, there are fewer mental health services than substance use services.
- Despite efforts to ensure availability, the distribution of medications in jails is often disrupted.
- Medications are not always maintained for those returning from a state hospital to a correctional facility because individuals can refuse medications and providers cannot force medication compliance.

- Implementation challenges of sections 9-603 and 9-603.1 of the Correctional Services Article Correctional vary. Common barriers include costly medications, lack of funding, and difficulty collecting and reporting data. Notably, this policy does not apply to prisons, and individuals returning from prisons are not provided the same services.
- The quality of care per provider varies, leading to a potential for outcome inequity, delayed recovery, and reduced trust in the system, which can undermine the overall effectiveness of treatment and support services.
- Early reentry support services within detention centers are needed.
- Stakeholders report that releases from jail outside of business hours may create barriers to connecting individuals to resources.

Capacity Constraints:

- Support with case management for individuals sentenced and released is needed. Notably, case management delivery varies across jurisdictions.
- Inpatient programs often have waitlists due to a shortage of available beds.

Transportation:

- Incarcerated individuals are sentenced to conditional releases, but cannot fulfill obligations due to a lack of housing and transportation options.
- Transportation options vary across jurisdictions but are commonly lacking for individuals seeking care and services. Summit participants noted that collaborating with local transit authorities and community partners to establish bus stops or improve transportation routes has enhanced access to treatment and services for individuals.

Support Services:

- Many peer support positions are grant-funded and not self-sustaining.
- Family support services are needed across intercepts; resources from the Maryland Coalition of Families were shared during the discussion of this need.

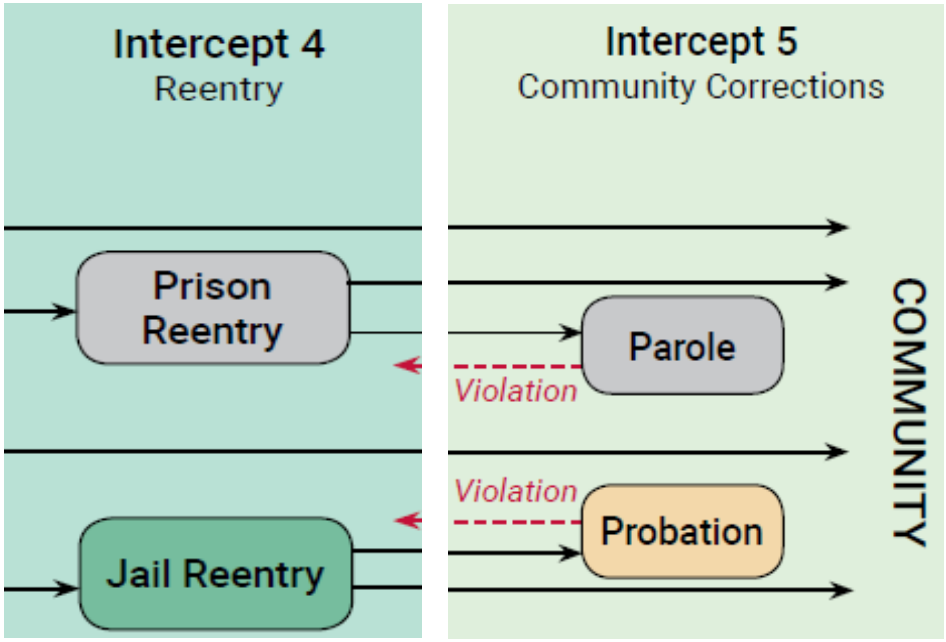
Data Collection and Sharing:

- Outcome measures and definitions of measures may vary across assessments and agencies.
- A shared data system is needed to track services, including routinely tracked data on racial and ethnic disparities and longitudinal data.
- Notably, data sharing is limited when it comes to aftercare. This gap hinders the ability of service providers to offer coordinated, informed, and seamless support, potentially leading to disruptions in care, duplication of efforts, or missed opportunities for early intervention.

Intercepts 2-3 Priorities

1.	Strengthen legislative support for implementing programs and mandates, especially those without allocated funding.	18 votes
2.	Develop universal prescreening tools during initial detention and hearings to enhance diversion opportunities.	11 votes
3.	Enhance reentry support before release from incarceration.	9 votes
4.	Formalize pretrial services and/or units that are individualized per jurisdictional needs.	9 votes
5.	Enhance data collection and sharing efforts.	6 votes
6.	Boost workforce development to assist with staff shortages.	5 votes
7.	Increase collaboration across intercepts for positive outcomes.	5 votes

Intercepts 4 and 5



Resources

Corrections-Based Reentry Services: Corrections professionals provide reentry services and referrals before release and supervision following release. Local detention center reentry, prison reentry, and parole and probation represent levels of reentry with unique demands.

- Reentry specialists develop reentry plans and provide linkages to benefits and referrals to treatment services. They connect individuals without housing to transitional housing, which includes wraparound services for continuity of care. They assist individuals with completing applications for public health insurance, documenting disability when appropriate, and requesting a transfer of supervision to/from out of state through the Interstate Compact Offender Tracking System (ICOTS). By completing intakes and paperwork before release, individuals are equipped for a smoother transition.
- Peer recovery specialists (PRS) and peer supervisors operate in some facilities to assist incarcerated individuals. The success of PRS-provided services is due to the connection of shared experience that fosters trust and bridges the gap between the system and the clients. Funding is available to facilitate the implementation of peer professional roles.

- Although the Office of the Public Defender does not formally create reentry service plans for the courts, they reportedly frequently provide these plans to be included in conditions of release.
- Through the Justice Reinvestment initiative, the Division of Parole and Probation strives to dispel the historically adversarial understanding of supervision. Supervisors complete mandated training on mental health and substance use disorders and provide referrals to the community for resources and graduated sanctions when permitted by the court with the ultimate goal of successful termination of supervision.
- The DPSPS Division of Parole and Probation maintains specialized caseloads based on offense: sexual, domestic violence, interstate, drug-related, pretrial services investigation, and individuals assigned to the violence prevention initiative via screening for individuals under the age of 30. New policies are being designed to increase staff in every county to assist with the mental health caseload.
- Work release programs can positively impact post-release employment rates and may lead to a reduction in recidivism.

Community-Based Reentry Services: Formerly incarcerated individuals seek an array of support and services from government agencies and community partners. Needs include funding, behavioral health services, professional development, legal assistance, housing, transportation, and family services.

- 211 acts generally as a no-wrong-door call center. Designed regionally, callers can be connected to local resources with a warm handoff.
- A dynamic network of resources is essential to meet client needs; the expansion of community partners in recent years is a step in building that resource-heavy network. As noted in previous SIM Summits, an increasing number of nonprofit organizations are supporting reentry initiatives.
- Peer recovery specialists in the community provide mentorship and assist reentering individuals with obtaining necessities such as identification, housing, behavioral health services, school enrollment, and insurance. As mentioned, funding is available to implement peer professional roles.
- The SSI/SSDI Outreach, Access, and Recovery (SOAR) program improves Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) application outcomes for adults experiencing homelessness and living with behavioral health conditions. SOAR specialists are utilized throughout the State, and jurisdictions are reportedly seeking opportunities to expand trained personnel to meet demand.
- The Maryland State Department of Education Division of Rehabilitation Services (DORS) and the Maryland State Department of Labor (DOL) assist with training, job coaching, resume building, workforce opportunities, and education, including preparation for the GED tests.

    - The DOL Division of Workforce Development and Adult Learning is the State's main workforce development entity and oversees the operation of Maryland's 30 American Job Centers located in each county of the State. At these American Job Centers, Marylanders actively participate in interview workshops as well as receive information on job training programs and résumé assistance.
    - The U.S. Department of Labor Reentry Employment Opportunities (REO) program provides funding, authorized as Research and Evaluation under Section 169 of the Workforce Innovation and Opportunity Act (WIOA) of 2014, for systems-involved youth and young adults and adults who were formerly incarcerated for the development of strategies and partnerships that facilitate the implementation of successful programs at the state and local levels to improve the workforce outcomes for this population.
    - In Anne Arundel County, an inter-agency collaboration including the Department of Labor aids with securing employment for individuals preparing for release.
- Outreach and low-threshold models are being deployed to meet individuals where they are to connect them to services. In communities where services have limited availability due to lack of providers or insufficient provider capacity, tapping into existing hub and spoke models is one way to expand client access. Communities utilize mobile wellness vehicles to provide virtual and in-person recovery services and link individuals to other community service providers. These efforts are improving client access to psychiatric, behavioral health, and medication-assisted treatment (MAT) services.
- "One Stop Shop" resource centers are expanding. In Prince George's County, the Bridge Center at Adam's House assists formerly incarcerated individuals as well as Veterans and young adults (aged 18-24) seeking stability in the community. This community resource center is funded through partnerships with health department agencies, the Department of Corrections, community organizations, and faith-based partners.

Gaps

Corrections-Based Reentry Services:

- Gaps in communication and information sharing between reentry systems have a direct negative impact on already-vulnerable populations.
    - Given that evaluations are performed by several entities, a regular multidisciplinary review meeting with individuals and vested parties would ensure seamless communication.
    - Specificity regarding jurisdiction is essential, as clients coordinate with the Office of the Public Defender before, during, and after release from incarceration.

        - Efforts made before a release may not always be communicated or maintained after the release for various reasons. Parole and probation supervisors may not have access to records and release plans if an individual does not provide them. Formal collaboration with the Department of Parole and Probation and enhanced relationships with its agents can improve service coordination.
- Strategies that address the language access needs of diverse and non-English language preference (NELP) consumers are needed to ensure timely evaluations and promote person-centered care.
- Whenever possible, treatment and services should be initiated before release. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive and integrated approach to the delivery of early intervention and treatment services through universal screening for persons with substance use disorders and those at risk. The number of positive SBIRT screenings demonstrates the need for detection and treatment in detention centers.
    - To ensure continuity of care, individuals should be encouraged to apply for insurance before release, enabling them to access health care immediately upon reentry. Access to health care asset management has been offered but may be underutilized as a strategy to address this obstacle.
- Professionals require education to expand the perception of treatment beyond simply medication.
- Unplanned releases are a widely acknowledged statewide challenge, reducing the time available to coordinate necessary supports including transportation from incarceration. This lack of preparation can complicate the reentry process, hindering effective reintegration into the community, increasing the risk of recidivism, and making it difficult to ensure that individuals receive the assistance they need. Unplanned releases are especially problematic in regard to providing proper identification, without which housing, employment, and social services are difficult to access. For the significant percentage of the in-custody population receiving pretrial supervision, these challenges are amplified by uncertainty surrounding benefits activation.
    - To address concerns, stakeholders recommend initiating reentry planning upon entry and planning for the earliest opportunity for release; this process is facilitated by local detention center reentry teams being notified when court hearings with release potential are approaching.

Community-Based Reentry Services:

- Jurisdictions across the State acknowledge the need for improved coordination between corrections-based reentry services and community-based reentry services to ensure a seamless transition through continuous support and access to essential resources.

    - A resource library is a hub of resource links, documents, tools, templates, checklists, and best practices critical to building services and capabilities that enhance effective information sharing and analysis within any community of interest. Stakeholders have proposed creating a resource library specifically for reentry services. By centralizing these resources, support networks for currently and formerly incarcerated individuals can more easily access and identify available services.
- Housing is an identified gap across intercepts that presents unique challenges based on need.
    - Broadly, affordable housing presents an issue for Maryland residents, impacting access to safe and suitable living arrangements and community resources including but not limited to reentry-related services.
    - Transitional housing is absent at the state level for individuals who are not diagnosed with mental health or substance use conditions (or do not admit to these conditions).
    - The State generally lacks sufficient housing for the following populations: individuals with severe mental illness; sex offenders and sex offenders with disabilities; individuals utilizing addiction medication(s); and individuals seeking sober living options.
- Transportation plays a key role in determining access to reentry-related services; unfortunately, access to transportation varies widely across jurisdictions and disproportionately impacts rural communities.
- Adequate coverage requires additional peer recovery specialists (PRS) and peer supervisors throughout the State.
- Limitations on services for populations create obstacles to successful reentry.
    - Individuals identified as sex offenders struggle to locate housing, treatment, and employment.
    - Substance use services are categorized based on the specific substance involved. While opioid addiction receives significant attention, support for treating alcohol or cocaine addictions is comparatively limited.
    - Every reentering individual needs support, but many resources are focused on addressing substance use and mental health issues. As a result, individuals without these challenges may not qualify for certain programs or types of assistance, such as subsidized housing.
    - Summit participants report that incarcerated individuals may feel pressured into self-identifying with mental health or substance use concerns to access support and services, increasing the risk of low-risk individuals being placed in high-risk programs. Addressing this gap will require creating separate programs tailored to

individuals without substance use or mental health needs. Simply expanding eligibility is not a viable solution, as placing low-risk individuals in high-risk programs can lead to unintended negative outcomes.
    - The emerging adult population is linked to the highest recidivism rate but is underresourced; stakeholders express interest in the development of specific supervision for this population. Similarly, youth who are charged as adults have no appropriate services. Other than the foster care system, there are few resources for transition-aged youth.

Workforce and Organizational Development:

- Grant funding for reentry initiatives is available, but accessing it can be challenging. Agencies and nonprofit organizations often require training and technical assistance to help their staff effectively identify and secure funding.
    - Organizations competing for funding may be disinclined to collaborate; however, administering agencies frequently prioritize collaboration in their evaluations. Further, these agencies often offer grant writing training and expanded funding opportunities from which organizations can benefit.
- Staffing shortages across the State impact the availability of services. Workforce development efforts can and should prioritize the recruitment and retention of qualified staff that can adequately address demand. To strengthen the systems, agencies should explore opportunities for educational bonuses while working to remove funding barriers and improve compensation in part through increased reimbursement rates.
- Parole and probation agents may not consistently raise awareness of available resources, leading to underutilization and challenges in client compliance with case plans. To address this, agencies should assess staffing capacity and consider incorporating peer support. Peers can provide meaningful one-on-one interactions with clients, allowing supervisors to focus on intensive supervision despite heavy caseloads. Additionally, peers are uniquely suited to bridge service gaps by helping clients connect with needed resources, a role supervisors may be less equipped to fill effectively.
- There is no shortage of peers interested in peer professional work, but role clarity is lacking and barriers exist that keep peers from entering this intercept. Free and low-cost training for peers is available, and an administrator series is scheduled for release in the coming months. Additionally, certifications require refreshers to avoid expiration, but consistent access to this training is challenging for peer professionals.
    - Opportunities abound to embed peers in community settings such as libraries and within corrections through jails, parole, and probation.
- Organizations are coping with lagging technology that hampers productivity.
- Trauma-informed care has gained significant attention due to the high prevalence of trauma among individuals involved in the criminal legal system.

- The GAINS Center provides the training, “How Being Trauma-Informed Improves Criminal Justice Responses,” which includes modules geared to key justice sectors across the five intercepts, including law enforcement, courts, jails/prisons, probation, and parole. The training also highlights how individuals can be re-traumatized at various points of the system, such as during arrest, detention, court proceedings, or incarceration.
- Given that trauma is a significant contributing factor to mental health conditions, such as anxiety, depression, and post-traumatic stress, communities should assess how systems identify, divert, and address justice-involved persons affected by trauma.

Intercepts 4-5 Priorities

1.	Expand access to community-based case management.	12 votes
2.	Ensure parity in the competitive grant process through training, promotion of collaborative applications, and expanded funding opportunities.	9 votes
3.	Curate a resource library to enhance information sharing and improve access for justice-involved persons and their support networks.	8 votes
4.	Enhance peer workforce development and funding for peer professionals.	8 votes
5.	Increase collaboration between local and state facilities to ensure continuity of care.	6 votes
6.	Broaden educational platforms for trauma-informed approaches to improve strategies for identifying, diverting, and addressing justice-involved persons who have experienced trauma.	6 votes
7.	Boost workforce development for all health care providers.	2 votes

Priorities Across Intercepts

Based on a voting process on day two of the Summit, focus groups identified topics that were most important to them. Following the voting process, the Centers of Excellence summarized priorities into a comprehensive chart (*as illustrated below*). Some priorities were mentioned across all intercepts and thus highlighted in an additional category.

Intercept 0/1	Intercept 2/3	Intercept 4/5	Across Intercepts
Ensure equitable funding of crisis services, including mobile crisis and stabilization services. (19)	Strengthen legislative support for implementing programs and mandates, especially those without allocated funding. (18)	Expand access to community-based case management. (12)	**Strengthen and expand the behavioral health workforce. (22)**
Enhance first responder wellness. (14)	Develop universal prescreening tools during initial detention and hearings to enhance diversion opportunities. (11)	Ensure parity in the competitive grant process through training, promotion of collaborative applications, and expanded funding opportunities. (9)	**Enhance collaboration across health care, public safety, and community services. (18)**
Explore emergency petition reform. (12)	Enhance reentry support before release from incarceration. (9)	Curate a resource library to enhance information sharing and improve access for justice-involved persons and their support networks. (8)	**Improve data sharing and resource access for continuity of care. (16)**
Enhance hospital collaboration with partners in health care, public safety, and community services. (7)	Formalize pretrial services and/or units that are individualized per jurisdictional needs. (9)	Enhance peer workforce development and funding for peer professionals. (8)	

Develop a behavioral health workforce pipeline. (7)	Enhance data collection and sharing efforts. (6)	Increase collaboration between local and state facilities to ensure continuity of care. (6)	
Expand service access and provider choice across the behavioral health continuum of care. (2)	Boost workforce development to assist with staff shortages. (5)	Broaden educational platforms for trauma-informed approaches to improve strategies for identifying, diverting, and addressing justice-involved persons who have experienced trauma. (4)	
Facilitate data and information sharing for continuity of care. (2)	Increase collaboration across intercepts for positive outcomes. (5)	Boost workforce development for all health care providers. (2)	

Strengthen and Expand the Behavioral Health Workforce

Strengthening and expanding the behavioral health workforce is essential to meet the increasing demand for mental health and substance use services, especially as staffing shortages continue to strain health care systems. Key priorities include developing a strong pipeline of behavioral health professionals, addressing workforce gaps through targeted development initiatives, and supporting growth across all health care sectors. Additionally, enhancing peer workforce development and increasing funding for peer professionals is critical, as they play an important role in providing support and improving access to care. Investment in ongoing training, mentorship programs, and career development opportunities can boost employee satisfaction, reduce turnover, and help foster expertise, understanding of client needs, and the ability to build meaningful therapeutic relationships. Supporting work-life balance, offering stress management resources, and cultivating a positive work environment are also key to ensuring the well-being and longevity of behavioral health professionals. These efforts are critical for addressing workforce shortages, retaining experienced staff, and attracting new talent to the field. Given the significant burnout many providers face, which negatively impacts the quality of care and leads to higher turnover rates, these investments are vital to ensuring sustainable, high-quality services that improve patient outcomes and meet community needs. Below are some resources relating to the cultivation of the behavioral health workforce.

- Health Management Associates. (2021). *Behavioral Health Workforce is a National Crisis: Immediate Policy Actions for States*. healthmanagement.com/wp-content/uploads/HMA-NCMW-Issue-Brief-10-27-21.pdf
- Maryland Hospital Association. (2022). *2022 State of Maryland's Health Care Workforce Report*. https://mhaonline.org/wp-content/uploads/2023/02/2022-State-of-Maryland-s-Health-Care-Workforce-Report.pdf
- Maryland General Assembly. (2023). Mental Health Workforce Development Fund Established (SB283/CH286). https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0283?ys=2023RS
- National Institute for Health Care Management Foundation. (2023). The Behavioral Health Care Workforce. https://nihcm.org/publications/the-behavioral-health-care-workforce-shortages-solutions
- Substance Abuse and Mental Health Services Association. (2022). *Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies* (Publication No. PEP22-06-02-005). store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep22-06-02-005.pdf

Enhance Collaboration Across Health Care, Public Safety, and Community Services

As demonstrated in the Summit presentations, collaboration and coordination between behavioral health and public safety systems are essential for promoting community well-being and effectively addressing complex challenges. By integrating perspectives and resources, these partnerships offer a comprehensive approach that balances immediate safety concerns with the need to address underlying behavioral health conditions driving certain behaviors. Such coordination supports the early identification of individuals at risk, enabling preventative interventions that can de-escalate potential crises and reduce emergencies. Moreover, collaborative efforts enhance mutual understanding among professionals, breaking down stereotypes and reducing stigma around mental health, leading to more empathetic and informed responses to individuals in crisis. The Centers of Excellence continue to enhance collaboration and coordination across agencies through jurisdictional and regional SIM mapping workshops by gathering stakeholders to work together and identify diversion and deflection strategies. The Centers also use *Maryland's Behavioral Health and Public Safety Center of Excellence Strategic Plan* (2023) which includes recommendations, objectives, and priorities related to cross-system collaboration and centralized communication. Below are some

resources relating to the importance of collaboration between agencies working toward the same goal.

- Bunger, A.C., Chuang, E., Girth, A. et al. (2020). Establishing cross-systems collaborations for implementation: protocol for a longitudinal mixed methods study. Implementation Sci 15, 55. https://doi.org/10.1186/s13012-020-01016-9
- Reist, C., Petiwala, I., Latimer, J., Raffaelli, S. B., Chiang, M., Eisenberg, D., & Campbell, S. (2022). Collaborative mental health care: A narrative review. Medicine, 101(52), e32554. https://doi.org/10.1097/MD.0000000000032554
- Substance Abuse and Mental Health Services Administration. (2023). *Care Coordination for Certified Community Behavioral Health Clinics (CCBHCs)*. https://www.samhsa.gov/certified-community-behavioral-health-clinics/section-223/care-coordination
- The Council of State Governments Justice Center. (n.d.). *Police-Mental Health Collaboration Programs: Checklist for Behavioral Health Agency Leaders*. https://csgjusticecenter.org/wp-content/uploads/2020/02/Checklist_BH-Agency-Leaders.pdf

Improve Data Sharing and Resource Access for Continuity of Care

Improving data sharing and resource access is vital for ensuring continuity of care, particularly for justice-involved individuals who rely on coordinated support across multiple systems. Facilitating data and information sharing, enhancing collection efforts, and curating a comprehensive resource library can bridge gaps in care and empower individuals and their support networks. Without effective data sharing, critical information is often siloed, leading to fragmented care, delays in service delivery, and poor outcomes for those in need. Conversely, improving data sharing and resource access promotes collaboration among providers, ensures timely interventions, and enhances the ability of justice-involved individuals to navigate available supports, ultimately improving health, stability, and reintegration outcomes. Notably, the Centers of Excellence developed a Sequential Intercept Model (SIM) Mapping Dashboard to visually present workshop outcomes and accompanying reports, providing detailed insights into available resources and identifying gaps in services within each county that has completed a mapping. This dashboard promotes data sharing and access to resources by centralizing information, fostering transparency, and equipping stakeholders with the tools needed to address service gaps and enhance system-wide coordination. Additionally, *Maryland's Behavioral Health and Public Safety Center of Excellence Strategic Plan* (2023) includes recommendations, objectives, and priorities related to the promotion of comprehensive and consistent data collection, management, and integration; advancements on data-related

initiatives will accelerate with the recent hiring of a dedicated data analyst. Below are resources that can be used for expanding data-driven strategies across intercepts statewide.

- Governor's Office of Crime Prevention and Policy. *Data Dashboards*. http://goccp.maryland.gov/data-dashboards/
- Governor's Office of Crime Prevention and Policy. *Grants Interactive Map.* https://goccp.maryland.gov/grants/
- Governor's Office of Crime Prevention and Policy. *Sequential Intercept Model (SIM) Mapping Dashboard*. https://gocpp.maryland.gov/data-dashboards/centers-of-excellence/sim-mapping-dashboard/
- Maryland Crime Research and Innovation Center. (2023). *Maryland's Behavioral Health and Public Safety Center of Excellence Strategic Plan*. https://goccp.maryland.gov/wp-content/uploads/Maryland%E2%80%99s-Behavioral-Health-and-Public-Safety-Center-of-Excellence-Strategic-Plan-7-24-23.pdf
- Opioid Operational Command Center. *Maryland Overdose Data Dashboard*. https://stopoverdose.maryland.gov/dashboard/
- US Department of Justice (DOJ) Bureau of Justice Assistance (BJA). (n.d.). *Delivering behavioral health.* https://bja.ojp.gov/program/pmhc/behavioral-health#information_sharing

RECOMMENDATIONS

Last year's Summit emphasized the critical need to incorporate trauma-informed care and address racial equity and disparities across all intercepts of the behavioral health and public safety systems. Recognizing the ongoing significance of these principles, the Centers continue to advocate for their integration while building on the foundation laid by the annual SIM Summits. For more information regarding last year's recommendations, please see the 2023 *State Summit on Behavioral Health and the Justice System* (report) at: https://gocpp.maryland.gov/wp-content/uploads/2023-State-Summit-Report.pdf.

Despite sustained efforts from committed individuals within law enforcement, the judiciary, corrections, community-based behavioral health, and advocacy, the barriers to improving the response to people with behavioral health needs persist at the local and state levels. This year's recommendation draws heavily from the priorities identified in the Summit's focus groups, reflecting a commitment to advancing equitable, compassionate, and effective approaches across all levels of intervention. An underlying prerequisite for effectively addressing the identified priorities is a data-informed planning framework. Jurisdictions must first address insufficient data and then collaborate to analyze and interpret the data, providing a meaningful foundation for informed decision-making. This approach leverages quantitative and qualitative data and ensures a balance of lived experience, professional knowledge, and robust data in decision-making processes.

The Stepping Up initiative is a complementary framework to the sequential intercept model; Stepping Up supports local jurisdictions in establishing and reaching measurable goals that demonstrate reduced prevalence of serious mental illness across the justice system. The initiative is based on a core set of principles and goals introduced in *Reducing the Number of People with Mental Illnesses in Jail: Six Questions County Leaders Need to Ask.* These questions can also serve as a framework for guiding recommendations that apply beyond serious mental illness to encompass the intersections of behavioral health, criminal justice, and public policy. The six questions and their corresponding answers are detailed below:

1. Is our leadership committed? Leaders must commit to a cross-system collaborative approach and fund system-level reform to effect desired change. Collaborative partners on the cross-system planning team must identify common goals, develop trust, and establish processes to synchronize efforts across diverse organizations with differing cultures, policies, priorities, authorities, capabilities, and procedures. Collaborative planning should always include the voices of people with lived experience to ensure that complex decisions include the perspective of the people impacted.

Notably, five Maryland counties (i.e., Anne Arundel, Calvert, Harford, Montgomery, and Prince George's) have passed Stepping Up resolutions.

2. Do we conduct timely screening and assessments? Early identification and screening are routinely characterized as lacking during local SIM mappings and at statewide summits and symposiums. First, established definitions that are consistently applied at local and state levels throughout the behavioral health and criminal legal systems are foundational for clearly defining eligibility for treatment and services. Second, an efficient process using validated screening and assessment tools for mental illness, substance use, and pretrial risk is essential to connection to appropriate services. Third and finally, effective information-sharing processes hinge upon protocols that facilitate system analysis and case management while adhering to privacy laws.

The Centers of Excellence is working to address all three requirements. The Centers have been collaborating with state agencies to develop a glossary of shared terminology. Staff are compiling best practices in data collection for screening processes and diversion outcomes in partnership with the Justice Reinvestment team to provide jurisdictions with a framework that promotes consistent, high-quality data management across the State. The Centers have developed a resource document on interagency behavioral health data-sharing that is available for immediate use; this document is part of a larger project to streamline data-sharing across agencies by addressing concerns of confidentiality and ethics.

3. Do we have baseline data? Official recidivism data in Maryland is often not tracked at the jurisdictional level due to inconsistent definitions and fragmented data management systems. A single, integrated information system that allows multiple agencies to enter and access data is the gold standard for establishing baseline data, sharing information, and tracking progress while also capturing connections to treatment and other data after community reentry.

4. Have we conducted a comprehensive process analysis and inventory of services? In addition to statewide SIM summits, the Centers of Excellence facilitate local and regional workshops using the sequential intercept model (SIM). The focus of each local workshop is the development of a sequential intercept model map. Facilitators work with the workshop participants to identify resources and gaps at each intercept. This process provides contextual information for understanding the local map as the criminal legal system and behavioral health services are ever-changing. Furthermore, this catalog can be used by planners to expand opportunities for improving public safety and public health outcomes for people with behavioral health conditions, intellectual and developmental disabilities (IDD), and neurocognitive conditions by addressing the gaps and building upon existing resources. A key benefit of local SIM mapping workshops is the reduction of information silos and the

facilitation of resource sharing, concerns that have been consistently raised statewide at the local, regional, and state levels. To illustrate these efforts, a data dashboard (described in the "Introduction" section) highlighting the completion of reports is accessible on the Office's website at: https://gocpp.maryland.gov/data-dashboards/centers-of-excellence/.

5. Have we prioritized policy, practice, and funding improvements? The individuals providing budget recommendations must understand the limitations (and opportunities) that distinct funding streams present. Proposals should identify external funding streams, including federal programs, federal grant opportunities, and state block grant dollars as the first source of funding. Local philanthropic support should also be considered. The final remaining gaps in funding should represent new jurisdictional investments. To effectively inform policy, process analysis should include the following: (1) data illustrating gap; (2) objective; (3) measure being addressed; (4) projected cost; and (5) identified sources of funding data to be tracked. This strategy prioritizes policy recommendations and budget requests that are practical, concrete, and aligned with local fiscal realities.

6. Do we track progress? Data that provides evidence of immediate accomplishments fuels the momentum and commitment necessary to ensure efforts continue. By tracking outcome data, decision-makers can justify continued or additional funding. Ultimately, data demonstrates progress, assures the community that concerns are being addressed, and ensures the sustainability of successful initiatives.

The recommendation to embrace data-informed decision-making recognizes that answering these questions alone is neither necessary nor sufficient to improve the response to individuals with behavioral health needs in the criminal legal system. While many jurisdictions can address some of these questions affirmatively, few if any, are equipped to address them all comprehensively. The challenges are multi-faceted, the resources are limited, and existing systems are complex and often difficult to align. However, adopting a data-informed framework can provide planners and leaders with valuable insights into current impacts and guide strategic planning efforts. This approach has the potential to enhance public safety, optimize resource use, and support recovery for individuals navigating these intersecting systems.

CONCLUSION

The 2024 *State Summit on Behavioral Health and the Justice System* (report) summarizes information gathered at this year's two-day convening. Last year's Summit marked a significant step forward in fostering collaboration and understanding between key stakeholders in addressing the complex intersection of behavioral health needs and the criminal legal system. Throughout the presentations and interactive focus groups, it became evident that fostering interagency collaboration and breaking down siloed efforts are essential to achieving meaningful progress. These themes emerged repeatedly as critical recommendations, alongside improving access to housing, cultivating the behavioral health workforce, and creating a shared data system. By emphasizing cross-agency collaboration, the 2023 Summit highlighted a path toward holistic solutions that reduce unnecessary interactions with the criminal legal system.

This year, 22 of the 24 jurisdictions in Maryland were represented at the event, with several attendees serving as statewide representatives. The Centers brought together professionals across all intercepts—spanning policymakers, law enforcement officials, mental health professionals, and community advocates—inviting them to collaborate in meaningful dialogue. By providing a platform for participants to exchange insights, share best practices, and explore innovative solutions, the Centers fostered a comprehensive and interconnected approach to addressing critical challenges. The discussions highlighted the complexity of the issues at hand, reinforcing the need to integrate mental health services, crisis intervention training, and community-based approaches into the criminal legal system. Collaboration continues to be a central theme in addressing the complex challenges at the intersection of behavioral health and the criminal legal system. Bringing together stakeholders across sectors allows for the sharing of diverse perspectives, the development of innovative solutions, and the alignment of resources to address gaps in care and services. Effective collaboration breaks down silos, fosters trust between agencies and communities, and ensures that interventions are more impactful, ultimately improving outcomes for individuals and reducing strain on public systems.

One key takeaway from the Summit is the critical importance of including individuals with lived experience, such as peer support specialists and certified peer recovery specialists, in this line of work. Their firsthand perspectives bring unique insights into the challenges faced by those navigating behavioral health and criminal legal systems, fostering greater understanding and empathy among stakeholders. For individuals who are incarcerated or navigating reentry, peer support can provide relatable guidance, reduce stigma, and create a sense of hope and empowerment. Integrating their expertise not only enhances the development of more effective, person-centered solutions but also builds trust and bridges gaps between systems and the communities they serve. The Summit also highlighted the critical need for improved data collection and sharing. This issue arises in multiple contexts, ranging from the absence of

effective data collection methods to significant barriers in sharing information across agencies. Many agencies express concerns about data privacy, lack of trust, or reluctance to share, even when collaboration could lead to better outcomes. Additionally, miscommunication or inadequate communication between stakeholders often exacerbates these challenges. As a result, the inability to collect, analyze, and share data effectively hinders the development of coordinated responses and informed decision-making. Addressing these barriers remains a pivotal step toward advancing cross-system improvements and achieving better outcomes for individuals in need.

The Centers are dedicated to advancing their mission by assisting, supporting, and fostering dialogue and program development focused on behavioral health and criminal legal initiatives throughout the State. Building on the momentum generated at the Summit, the Centers will continue to lead efforts to address the complex challenges highlighted in this report. By promoting collaboration among stakeholders, enhancing data-sharing systems, and amplifying the voices of individuals with lived experience, the Centers aim to develop innovative, person-centered solutions. The Centers remain dedicated to advancing cross-sector coordination, dismantling silos, and aligning resources to build a more effective and compassionate system. Through sustained engagement with stakeholders, the Centers will drive progress toward improving outcomes and addressing gaps in care and services statewide.

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PARTICIPANT LIST

Name (First, Last)	Title	Organization
Ajibike Salako-Akande	Chief Executive Officer	Getwele Recovery & Wellness Center
Alexandra Smith	Byrne State Crisis Intervention Program Coordinator	Governor's Office of Crime Prevention and Policy
Alexis Fryer	Team Supervisor	Maryland Coalition of Families
Alisha Saulsbury	Forensic Mental Health Manager	Mid Shore Behavioral Health
Amanda McCarty	Parent Advocate Peer Specialist	Maryland Office of the Public Defender
Amy Baker	Program Director - Special Populations	Carroll County Local Behavioral Health Authority
Ana Rivera Ortiz	Law Enforcement Assisted Diversion Project Coordinator	Howard County Health Department - Bureau of Behavioral Health
Anastasia Edmonston	Traumatic Brain Injury Partner Grant Coordinator	Behavioral Health Administration
Andrea Watkins	Associate Judge	Charles County District Court of Maryland
Angel Dalverny	MAT Program Coordinator/Registered Nurse	Allegany County Detention Center
Angela Shroyer	Problem-Solving Court Coordinator	Harford County District Court of Maryland
Anjohnetti Moore	Regional Reentry Specialist	Department of Public Safety and Correctional Services Division of Corrections
Ann Glodek	Mental Health Court Coordinator	Baltimore City District Court of Maryland
Annabelle Belcher	Assistant Professor	University of Maryland, Baltimore
Anne Pack	Co-Founder and Director of Advocacy	PREPARE

Bethany Young	Director of Policy and Legislation	Governor's Office of Crime Prevention and Policy
Bianca Bersani	Associate Professor and Director of MCRIC	Maryland Crime Research and Innovation Center
Bill Rhodes	Mental Health Coordinator	Wellpath
Brent Kluttz	Drug Intelligence Officer	High Intensity Drug Trafficking Area (HIDTA)
Brett Lysinger	Lieutenant	Maryland Sheriffs' Association
Bryan Pugh	Executive Director	Brain Injury Association of Maryland
Cara Y. Lewis	Associate Judge	Carroll County District Court of Maryland
Carrie Johnson	Executive Director	Washington County Mental Health Authority
Casey Crowley	Program Director	Sheppard Pratt
Catherine Gray	Clinical Director	Anne Arundel County Mental Health Agency
Charles Green Jr.	Director of Social Work	Maryland Office of the Public Defender
Cher Rivers	Peer Support	Frederick County Health Department
Christina Batze	Advanced Social Worker	Maryland Office of the Public Defender
Maria Morales	Administrative Assistant II	City of Laurel
Christopher Klein	Superintendent	Department of Detention Facilities
Christopher Shea	Program Manager	St. Mary's County Health Department
Darren McGregor	Director, Criminal Justice Services	Maryland Behavioral Health Administration
Denise Albright	Program Manager	Prince George's County Health Department

Derek Adams	Law Enforcement Assisted Diversion Coordinator	Calvert County Health Department
Diana Casey	Division Director	Gaudenzia (Crownsville Facility)
Donald Hall	Director of Behavioral Health Services	Dorchester County Health Department
Evan Langholt	Director of Homeless Housing Supportive Services	EveryMind
Gillian Tonkin	Senior Staff Attorney	Maryland Judiciary - District Court
Gray Barton	Behavioral Health Senior Program Manager	Maryland Judiciary
Heather Warnken	Executive Director, Center for Criminal Justice Reform	The University of Baltimore School of Law
James Carter	Peer Support Specialist/Certified Peer Recovery Specialist	Chesapeake Voyagers, Inc.
James Rhoden	Assistant Director of the Centers of Excellence	Governor's Office of Crime Prevention and Policy
James Widmyer	Clinical Supervisor	Allegany County Health Department/Joseph s. Massie Unit
Janay Tyler	Behavioral Health Services Coordinator	Charles County Local Behavioral Health Authority
Jennifer Corbin	Director	Anne Arundel County Crisis Response
Jennifer Clark	Clinical Program Supervisor	Sheppard Pratt
Jessica Marvel	Social Worker	Maryland Office of the Public Defender
Jessica Tuel	Director of Behavioral Health	Caroline County Behavioral Health
Joanie Shreve	Social Worker	Maryland Office of the Public Defender
Jocelyn Evens	Project Manager	Maryland Crime Research and Innovation Center
John Crouch	Associate Director of Crisis Services	Behavioral Health System Baltimore

John Moses	Director of Criminal Justice	Wor-Wic Community College and Eastern Shore Criminal Justice Academy
Kaely Whittington	Certified Peer Recovery Specialist Training Coordinator	On Our Own of Maryland
Kait Simon	Director of Peer Training Services	On Our Own of Maryland
Keesha Wallace	Judicial Treatment and Community Support	Department of Public Safety and Correctional Services
Keisha Shreeves	Reentry Specialist	Department of Public Safety and Correctional Services
Keith Lotridge	Deputy Public Defender, State of Maryland	Maryland Office of the Public Defender
Kimber Watts	Attorney	Maryland Office of the Public Defender
Kimberly Davis	Associate Judge	Baltimore County District Court of Maryland
Kristie Ardire	Pretrial Case Manager Supervisor	St. Mary's County Sheriff's Department
Kristin Leprich	Senior Behavioral Health Researcher	Maryland Judiciary
Kristy Blalock	Executive Director	Gaudenzia (Regional Office)
Latanya Barnes	Manager of the Utilization Review and Patient Analytics	Maryland Department of Health
Lindsay Tayman	Treatment Court Coordinator	Wicomico County Circuit Court of Maryland
Lisa Edwards	Case Manager	Baltimore City District Court of Maryland – Adult Recovery Court
Mallory Branham	Certified Peer Recovery Specialist and Parent Advocate	Maryland Office of the Public Defender
Mariah Shupe	CIT Coordinator	Affiliated Sante Group
Marie Liddick	Deputy Director, Bureau of Prevention, Wellness, and Recovery (Local Behavioral Health Authority)	Carroll County Health Department

Marina Sabett	Associate Judge	Montgomery County District Court
Marty Knotts	Individual with Lived Experience	Chesapeake Voyagers, Inc
Mary Becraft	Forensic Mental Health Case Manager	Mid Shore Behavioral Health
Maxine Curtis	Behavioral Health Senior Program Manager	Maryland Judiciary, Administrative Office of the Courts
Melissa Owens	Crisis Intervention Consultant and Person with Lived Experience	Patient Not Prisoner
Mohammad Ahmad	Division Director	Gaudenzia (Woodland Facility)
Patricia Ramseur	Prevention Coordinator	Prince George's County Health Department
Patrick Enweonwu	Regional Reentry Specialist	Department of Public Safety and Correctional Services
Paula Fish	Drug Court Program Manager	Anne Arundel County Circuit Court of Maryland
Pritesh Jain	Data Analyst	Maryland Crime Research and Innovation Center
Rachel Ames	Mental Health Coordinator, Centers of Excellence	Governor's Office of Crime Prevention and Policy
Robin Jones	Field Supervisor I	Department of Public Safety and Correctional Services
Sam Richberg	Chief of Programs	Affiliated Sante Group
Shaem Spencer	Administrative Judge	Anne Arundel County District Court of Maryland
Shariee Sims	Mental Health Professional	Howard County Health Department
Shina Castain-Thompson	Deputy of Administration	Department of Public Safety and Correctional Services
Stephanie Brehm	Reentry Coordinator	Allegany County Detention Center
Steven Thomas	Lieutenant	Anne Arundel County Police
Tammy Loewe	Behavioral Health Division Director	St. Mary's County Health Department

Tanya Schwartz	Director	Maryland Department of Health, Urgent and Acute Care
Tatiana Reyes	Policy and Advocacy Coordinator, Centers of Excellence	Governor's Office of Crime Prevention and Policy
Taylor Wilder	Prevention Specialist	Prince George's County Health Department
Terri Collins Green	Public Defense Social Worker	Office of the Public Defender
Thashana Mckinney	Minority Youth Outreach Program Facilitator	Wicomico County Health Department
Tija Jackson	Adult Recovery Court Case Manager	Baltimore City District Court of Maryland
Tina Foertschbeck	Peer Recovery Specialist Supervisor	Frederick County Health Department
Tj Humphries	Certified Peer Recovery Specialist and Certified Community Health Worker	Voices of Hope
Tommy Ervin	Agent Senior	Department of Public Safety and Correctional Services
Tracy Schulden	Deputy Director	Anne Arundel County Department of Health
Tyhesha Connell	Care Coordinator Supervisor	Gaudenzia (Park Heights Facility)
Tyler Hightower	Forensic Psychiatrist	Springfield Hospital Center
Valerie Williams	Field Supervisor II	Department of Public Safety and Correctional Services
Veronica Dietz	Director of Crisis Services	Carroll County Health Department
Yvette Hynson	Certified SOAR Case Specialist	Mid Shore Behavioral Health
Zulema Roberts	Mental Health Professional Counselor - Supervisor	Department of Public Safety and Correctional Services